

00-06290

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14790
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOLLIE S COEN			20. DATE OF DEATH MONTH DAY YEAR 5/5/86 HOUR MIN 6 55 M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7/20/1893	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	12b. KIND OF BUSINESS OR INDUSTRY Private
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Serby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Brodsky		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579 26 7667	17. INFORMANT ADDRESS Roger Friedman: 581 Greenwood Ave. N.E. Atlanta, Georgia 30308	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) GENERALIZED ARTERIOSCLEROSIS Approximate interval between onset and death: 5 MIN 20 YEARS 25 YRS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from 10/21 19 69 , to 5/5 19 86 that (we) last saw the deceased alive on 5/5 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)				
22b. SIGNATURE Steven Lipson		DEGREE MD	22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN LIPSON		22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Maryland		23e. DATE REG'D. BY REGISTRAR MAY 09 1986		
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Falls Church, VA		25. REGISTRAR'S SIGNATURE ...		

MEDICAL CERTIFICATION

BP

DHMH 7/86
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR FUNERARY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and completely filled in by the funeral director, page 3 should be delivered for use on the burial/transit permit. Then please remove this page from the certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. (IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified of once retained by the funeral director.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use on the burial/transit permit. Then please remove this page from the certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. (IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified of once retained by the funeral director.)

3302 COLTON ST

CHIEF WINTER



CHIEF WINTER

00-08363

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEALIA B COLEMAN					2a. DATE OF DEATH MONTH DAY YEAR 5 24 86					2b. HOUR 155^A	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 14 12			6. AGE (IN YEARS LAST BIRTHDAY) 74			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER			12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE VIRGINIA			13b. COUNTY CAROLINE		13c. CITY OR TOWN SPARTA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RURAL 22552 99999		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. JOHNSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE VESSELLS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 229 52 7333			17. INFORMANT HARRY COLEMAN			ADDRESS BOWLING GREEN, VA RFD RT 1 BOX 73		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemophy sis DUE TO, OR AS A CONSEQUENCE OF (c) 5 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 5/19/86 5/24/86						
22a. I certify that (I) (his hospital) attended the deceased from 5/24/1986 to 5/24/1986 , that (I) (we) lost the deceased on 5/24/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David Cromwell					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID CROMWELL, MD					22e. ADDRESS TAKOMA PARK, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-27-86		23c. NAME OF CEMETERY OR CREMATORY JERUSALEM CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE SPARTA, CAROLINE VA.			
24. FUNERAL DIRECTOR NAME Joseph E. Adams ADDRESS BOWLING GREEN VA DATE JUN 03 1986 REGISTRAR'S SIGNATURE John Davidson-Randall											

00-07259

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14192

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leona H. Conn		2a. DATE OF DEATH MONTH DAY YEAR 5/17/86		2b. HOUR 1 ^{PM}	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Sept. 2 '11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15301 Wallbrook Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Md	13b. COUNTY Mont. Co.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15301 Wallbrook Ct. 20906
14. FATHER'S NAME FIRST MIDDLE LAST Michael Honick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Borden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-38-3021		17. INFORMANT ADDRESS Andrew F. Conn; 2420 Diana Rd., Baltimore, Md. 21209	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>terminal metastatic lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3/16</u> 19 <u>86</u> to <u>5/17</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Marian Chung</u>		DEGREE <u>M.D. / Belknap M.D.</u>		22c. DATE SIGNED <u>5/17/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARIAN CHUNG, M.D. / Belknap M.D.</u>		22e. ADDRESS <u>3701 Rossmore Blvd SS Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-19-86		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.	
				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville, Md		25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

00-51523

8

DOX GILSON-LEDER

WILKINSON PATENT



3
00-078451- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 14793

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA LEE COOK			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1986		2b. HOUR 11:36P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 23, 1917		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Washington, D.C.		13b. COUNTY		13c. CITY OR TOWN		
14. FATHER'S NAME FIRST MIDDLE LAST Smalls Dunbar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Trottie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 578 24 9494		17. INFORMANT ADDRESS 5612 North Capitol Street Mrs. Eleanor Bartley-sister		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sudden</u> <u>years</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I, this hospital) attended the deceased from <u>5/16</u> , 19 <u>86</u> , to <u>5/20</u> , 19 <u>86</u> , that (I, we) last saw the deceased alive on <u>5/16</u> , 19 <u>86</u> , and that my (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		ATTENDING MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. SCHAUSCHER MD		22e. ADDRESS 7500 GABBERSWAY CTR. DR. GABBERSWAY MD 20770				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery Suitland, Maryland		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benn. Rd., N.E.		25. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

00-06455

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, there is only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 6/5/86 rja									
1. DECEASED NAME (TYPE OR PRINT) Antoinette, Corio						2a. DATE OF DEATH MONTH 05 DAY 09 YEAR 86		2b. HOUR 6:40 pm	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 01 DAY 01 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. UNDER 1 YEAR MONTHS 00 DAYS 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14635 Bauer Dr. 20853	
14. FATHER'S NAME FIRST Luigi MIDDLE - LAST Mangieri				15. MOTHER'S MAIDEN NAME FIRST Maddalena MIDDLE - LAST Amabile					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 089-28-2013		17. INFORMANT ADDRESS 10624 Seneca Ridge Dr. Gaithersburg, Md. 20879 Anthony Corio					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute Pulmonary Embolism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 5/9 19 86 , that (I) (we) lost saw the deceased alive on 5/9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel Golden				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Golden				22e. ADDRESS 10501 Old Georgetown Rd - Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR Donald Sandison Gartner Sandison F. H.				316 E. Diamond Ave Gaithersburg, Md. 20879		25a. DATE REC'D. BY REGISTRAR MAY 12 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

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2000

00-06296

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove contributors. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8614795 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAE B. CORNFELD					2a. DATE OF DEATH MONTH DAY YEAR May 5, 1986			2b. HOUR 2 30 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8925 Cherbourg Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8925 Cherbourg Drive (20854)	
14. FATHER'S NAME FIRST MIDDLE LAST Solomon Baum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bella Garfinkle		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (U.S. NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 171-32-2858		17. INFORMANT ADDRESS Ed. 20854 Edward Cornfeld; 8925 Cherbourg Drive; Potomac,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10 years</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>did not</u> attend the deceased from <u>Aug 5-5</u> 19 <u>83</u> to <u>5 May 1986</u> that (I) <u>do</u> saw the deceased alive on above, (I) <u>did</u> view the body after death.									
22b. SIGNATURE <u>Edward Cornfeld M.D.</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 5, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD CORNFELD, M.D.				22e. ADDRESS 20428 Germantown Road; Germantown, Md. 20874					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/6/86		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHPLS. 1170 Rockville Pike; Rockville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 09 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>			

BP

22

1950

00-06929

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14796

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR														
1. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
FRANK A COVER			Male			Caucasian			Dec. 17, 1907			78						5:45 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK OR LOSS OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Washington, DC			United States						Montgomery County MD			Landscape Machinist			Newspaper					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE											
Rockville			Rockville Nursing Home						16625 Killdeer Drive/20855											
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Charles			Annie			No			578-05-6795			Richard G. Cover, Sr. same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i>																				
DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <i>Pneumonia</i>			DUE TO, OR AS A CONSEQUENCE OF														
			(c) <i>Longstanding Chronic</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Slight Stroke Syndrome, Cardiovascular Accident, Organic Brain Disease</i>																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
			HOUR A.M. MONTH DAY YEAR						WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			CITY OR TOWN			COUNTY STATE					
			P.M. 19																	
22a. I certify that (1) (this hospital) attended the deceased from <i>June 19 84</i> to <i>Present</i> 19 <i>84</i> , that (b) (we) last saw the deceased alive on <i>5 17</i> 19 <i>84</i> , and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) not view the body after death.																				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
<i>D. Shumaker</i>									May 12, 1986											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																	
DOUGLAS R. SHUMAKER, M.D.			615 W. MONTGOMERY AVE. ROCKVILLE, MD 20850																	
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION											
Burial			May 15 1986			Ft. Lincoln Cem.			Brentwood, Maryland											
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Robert A. Pumphrey Funeral Homes			MAY 19 1986																	
300 West Montgomery Ave. Rockville, MD PA																				



0-07648

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86 14797 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JANET ELAINE CRAIG					2a. DATE OF DEATH MAY 16 1986			2b. HOUR 2:30 A	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH DECEMBER 19 1949		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
13a. STATE VIRGINIA		13b. COUNTY PRINCE WM.		13c. CITY OR TOWN WOODBIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13731 MAHONEY DRIVE 22193	
14. FATHER'S NAME HARRY GROVER CRAIG, JR.					15. MOTHER'S MAIDEN NAME MARY ANN RESCH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1975-1986		17. INFORMANT MARY A. CROWE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1986, to MAY 16, 1986, that (I) (we) lost saw the deceased alive on MAY 16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE J. M. GUINEE, LT, MC, USNR					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		23c. DATE SIGNED 19 May 86		
24. FUNERAL DIRECTOR NAME ADDRESS Colonial Funeral Home 6161 Leesburg Pike Fall Church, Virginia					25. DATE REC'D. BY REGISTRAR MAY 22 1986				
26. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					27. DATE May 21, 1986				
28. NAME OF CEMETERY OR CREMATORY Arlington National					29. LOCATION Arlington, Virginia				
30. DATE REC'D. BY REGISTRAR MAY 22 1986					31. REGISTRAR'S SIGNATURE John Davidson-Randall				

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

NOV 10 1964

00-06604

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITHIN 72 HOURS. WITHIN 72 HOURS, THE FUNERAL DIRECTOR SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14798

1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTIMATED										2b. HOUR																																																											
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE PRONOUNCED DEAD										2d. HOUR																																																											
ELIZABETH S CRAMER										5 11 1986										0855 M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.																													
F										C										12 04 23										62 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
PENNSYLVANIA										USA										WIDOWED										MONTGOMERY MD																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
ROCKVILLE										SMARY GROW HOSPITAL										HOME MAKER																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS										20879																													
MD										MONTGOMERY										GAITHERSBURG										YES										9416 AMBOY ROAD.																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMATION										ADDRESS																													
JOHN										ELIZABETH										NO										207-14-3202										SHANNON D. CRAMER, JR. HUSBAND SAME AS 13																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I DEATH WAS CAUSED BY:										ACUTE																																																																					
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																																					
MYOCARDIAL INFARCTION																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF																																																																					
ARTEROSCLEROTIC CARDIOVASCULAR DISEASE																																																																															
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
HYPERTENSIVE CARDIOVASCULAR DISEASE																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES										NO																																																	
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										1945 PM 5 11 1986										COLLAPSED AT HOME																																																											
21d. INJURY OCCURRED WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
NOT WHILE AT WORK										HOME										STREET										CITY OR TOWN										COUNTY										STATE																													
22a. I certify that I took charge of the remains described above, held on										Autopsy										Inspection										Inquiry										and in my opinion																																							
death resulted from										Natural causes										Accident										Suicide										Homicide										Undetermined manner																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
FRANCIS C MAYLE										M.D. DEPT										5/11/86																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (CITY OR TOWN)										COUNTY										STATE									
500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.																				BURIAL										MAY 15, 1986										ARLINGTON NATIONAL										ARLINGTON										VIRGINIA																			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
FRANCIS J. COLLINS, JR.										MAY 15 1986										John Davidson-Rodale																																																											

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- STATE REGISTRAR		66		14799		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Florence Evans Cramer					2a. DATE OF DEATH MONTH DAY YEAR MAY 25 '86					2b. HOUR 5:45 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 01 / 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE --- COUNTY ---		13b. CITY OR TOWN Washington, DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4000 Cathedral Ave, NW / 20016					
14. FATHER'S NAME FIRST MIDDLE LAST Henry -- Evans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret -- Morris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Nancy C. Ward, 5921 Kirby Rd, Bethesda, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRAABDOMINAL SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERFORATED SIGMOID COLON</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIVERTICULITIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION 5/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED SIGMOID COLON DIVERTICULITIS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/24/1986</u> to <u>5/25/1986</u> that (I) (we) last saw the deceased alive on <u>5/24/1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Goicochea</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/25/86.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUVENAL R. GOICOCHEA				22e. ADDRESS 8218 Wisconsin Ave. #106 BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/86		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

Approved by the Board of Directors

James M. Smith



1998-2-14

James M. Smith, President
James M. Smith, Secretary
James M. Smith, Treasurer
James M. Smith, Director

00-08329

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the completed page 3 to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause of death, the medical examiner will conduct an autopsy.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14800
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MAE Crawford			2a. DATE OF DEATH MONTH DAY YEAR 5-30-86		2b. HOUR MIN. 11:45 A		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9-15-98		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. CITY OR TOWN Charles Waldorf		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Box 231 Route 228 20601	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Fox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Bower		16. ADDRESS 15231 Red Clover Dr. Jon Crawford-son-Rockville, Md. 20853			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 218-54-8248		17. INFORMANT Jon Crawford-son-Rockville, Md. 20853			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Right hemispheric cerebral infarct DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal insufficiency - electrolyte abnormalities							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 29th , 19 86 , to May 30th , 19 86 , that (I) (we) last saw the deceased alive on May 30th , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)							
22b. SIGNATURE Edward S. Mehlman, M.D., FCCP				DEGREE M.D., FCCP		22c. DATE SIGNED 5/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD S. MEHLMAN, M.D., FCCP				22e. ADDRESS 5625 BRADLEY BOULEVARD BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg. Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. Inc				ADDRESS 11800-N.H.Ave. Sil.Spg.Md.		25a. DATE REC'D. BY REGISTRAR JUN 3 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

Page 2 of 2



00-07270

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14801

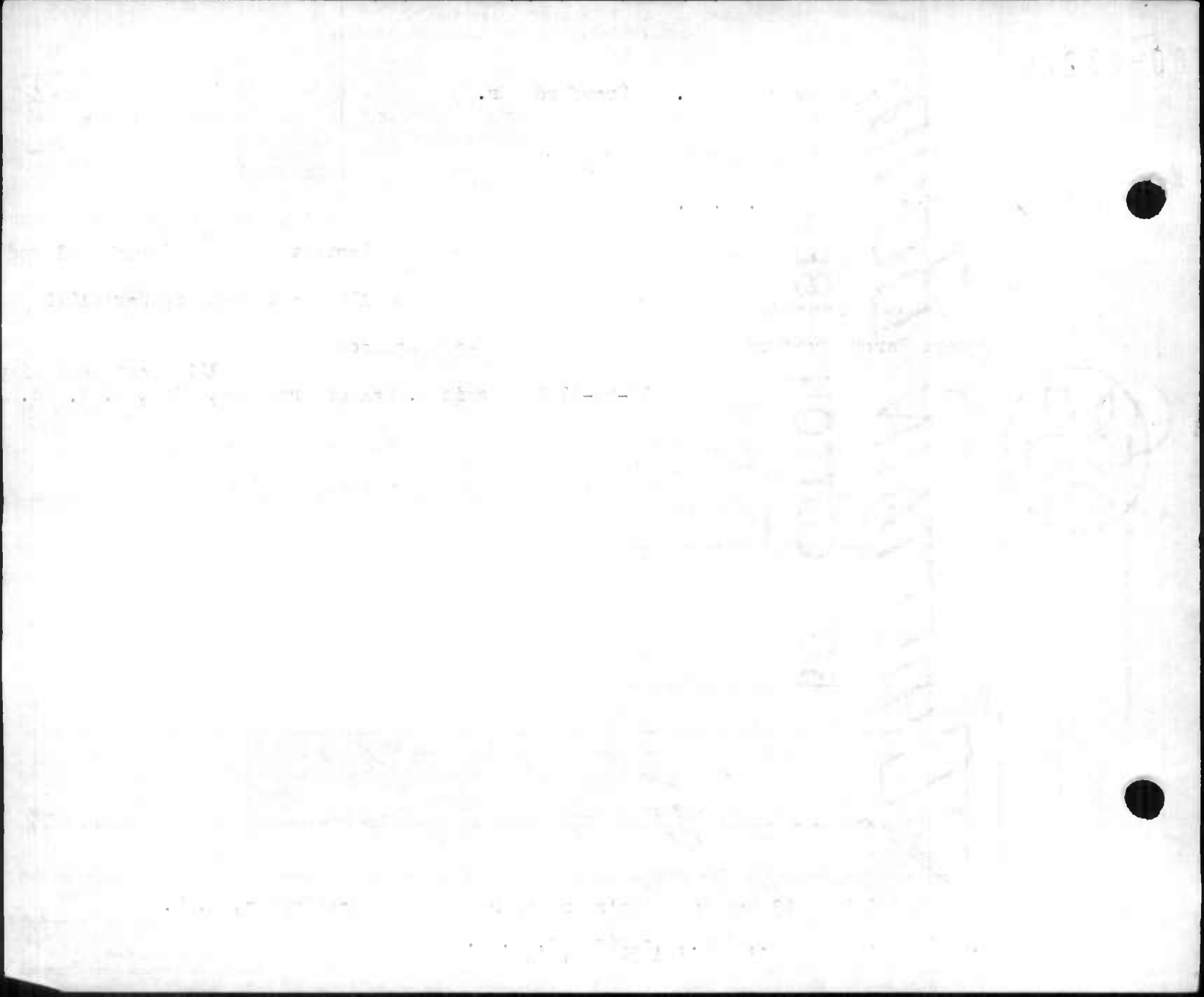
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																					
1. DECEASED NAME (TYPE OR PRINT)										2b. DATE KNOWN OF DEATH										2b. HOUR																																																																					
St Elmo W. Crawford Sr.										May 12 1968										6:45 P.M.																																																																					
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.										9. DATE PRONOUNCED DEAD										10. BALTIMORE CITY OR COUNTY OF DEATH																			
M										W										May 12 1968										21 YRS.										MONTHS										DAYS										HOURS										MIN.										MONTGOMERY MD.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										10. BALTIMORE CITY OR COUNTY OF DEATH																																																	
Florida										U. S. A.										NEVER MARRIED										MONTGOMERY MD.										MONTGOMERY MD.																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
220 Park										Wash. Advent. Hosp										Dentist										Self Employed																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																	
MD										Mont										P. T. Spg										YES										1220 East West Highway #1212																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																							
Robert Percy Crawford										Pearl Wallace										Yes										578-54-7743										Mamie E. Walker Crawford, Wife, S. S. Md.										1220 East West Hwy																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																																	
PART I DEATH WAS CAUSED BY:										PART I DEATH WAS CAUSED BY:										PART I DEATH WAS CAUSED BY:										PART I DEATH WAS CAUSED BY:										PART I DEATH WAS CAUSED BY:																																																	
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19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										20. AUTOPSY?										20. AUTOPSY?																																																	
None										None										YES										NO										NO																																																	
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21c. HOW INJURY OCCURRED										21c. HOW INJURY OCCURRED																																																	
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21d. INJURY OCCURRED										21e. PLACE OF INJURY										21e. LOCATION										21e. LOCATION										21e. LOCATION																																																	
WHILE AT WORK										STREET, FACTORY, FARM, ETC.)										STREET										CITY OR TOWN										COUNTY										STATE																																							
22a. I certify that I took charge of the remains described above, held on										22a. I certify that I took charge of the remains described above, held on										22a. I certify that I took charge of the remains described above, held on										22a. I certify that I took charge of the remains described above, held on										22a. I certify that I took charge of the remains described above, held on																																																	
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Natural causes										Accident										Suicide										Homicide										Undetermined manner										Undetermined manner																																							
22b. I certify that I took charge of the remains described above, held on										22b. I certify that I took charge of the remains described above, held on										22b. I certify that I took charge of the remains described above, held on										22b. I certify that I took charge of the remains described above, held on										22b. I certify that I took charge of the remains described above, held on																																																	
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W. Ernest Jarvis Co., Inc.										W. Ernest Jarvis Co., Inc.										W. Ernest Jarvis Co., Inc.										W. Ernest Jarvis Co., Inc.										W. Ernest Jarvis Co., Inc.																																																	
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										23d. LOCATION																																																	
CREMATION										13 May 86										Lee's Crematory										Washington n, D. C.										Washington n, D. C.																																																	
24. FUNERAL DIRECTOR										24. FUNERAL DIRECTOR										24. FUNERAL DIRECTOR										24. FUNERAL DIRECTOR										24. FUNERAL DIRECTOR																																																	
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25a. DATE REC'D. BY REGISTRAR										25a. DATE REC'D. BY REGISTRAR										25a. DATE REC'D. BY REGISTRAR										25a. DATE REC'D. BY REGISTRAR										25a. DATE REC'D. BY REGISTRAR																																																	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25AM

BP
DHMH - 17
(VR A15 ME (5))



0-09332

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8614802 REG. NO.				
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank F. Critzer					2a. DATE OF DEATH MONTH DAY YEAR 5 / 22 / 86			2b. HOUR 3:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22, 1905		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS.		7. UNDER 1 YEAR MONTHS DAYS 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Batesville, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH North C. MD.			
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Grocery		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Wesley Critzer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clemmy Louise Critzer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
		16b. SOCIAL SECURITY NO. 227-28-7721		17. INFORMANT ADDRESS Mr. William D. Critzer					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minute
DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Bowel Disease with Shock									3 days
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) Chronic Obstructive Pulmonary Disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the undersigned) attended the deceased from 5/19 19 86 , to 5/22 19 86 , that (I) (the undersigned) saw the deceased alive on 5/22 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE Carl Schoenberger					DEGREE MD			22c. DATE SIGNED 5/22/86.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl Schoenberger					22e. ADDRESS 16220 Frederick Rd Gaithersburg.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Ch. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Batesville Albemarle Va.		
24. FUNERAL DIRECTOR NAME John W. Anderson					25. DATE REC'D. BY REGISTRAR June 13, 1986		25b. REGISTRAR'S SIGNATURE John W. Anderson		

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JAMES EARL RAY

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-19-2010 BY 60322 UCBAW/SJS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 14803 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LORETTA MAGDELINE CRONEMEYER					2a. DATE OF DEATH MONTH DAY YEAR MAY 27 1986			2b. HOUR 12:45 P			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 26 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ODENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 592 CHAPEL GATE DRIVE 21113			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS LEE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MCCABE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT (HUSBAND) ADDRESS BENJAMIN CRONEMEYER, 592 CHAPEL GATE DRIVE, ODENTON, MD 21113							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from MARCH 24, 19 86, to MAY 27, 19 86, that (I) (we) last saw the deceased alive on MAY 27, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. M. Guinee MD					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 28 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. GUINEE, LT, MC, USNR					22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 5/28/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009					25a. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Grimsley Edelin Crum			2a. DATE OF DEATH MONTH DAY YEAR May 1, 1986			2b. HOUR 12:55a _M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 23, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		8b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5521 Brite Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Noble Edelin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Nucent Killingsworth			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 217-28-1964			17. INFORMANT Nancy Doll 1700 South State Street # 53 Hemet, California 92343 (Daughter)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5:23, 19 58, to 5:10, 19 86, that (I) (we) lost saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James Mackin MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED May 1, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Mackin, M.D.				22e. ADDRESS 5401 Western Avenue N.W. Washington D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a. DATE REC'D BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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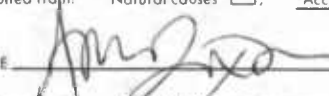
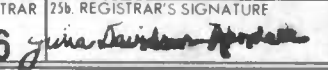


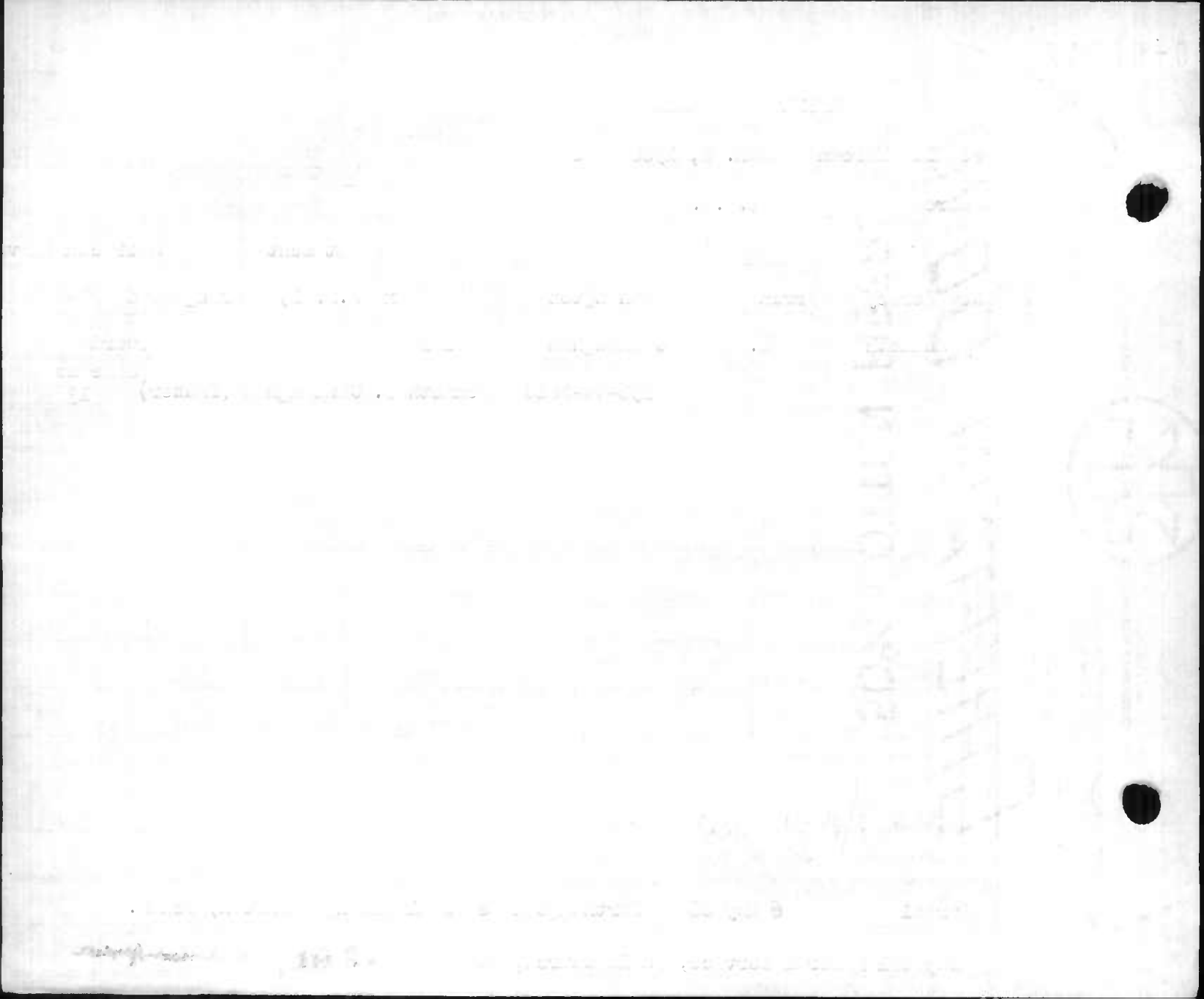
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM (PM) 1 WITHIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14805			
1. DECEASED NAME (TYPE OR PRINT) REBEKAH ANN CUNNINGHAM										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 3 YEAR 1986		2b. HOUR M	
1. SEX Female		4. RACE Korean		5. DATE OF BIRTH MONTH Jan. DAY 1 YEAR 1966		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH 5 DAY 3 YEAR 1986		7d. HOUR 2:48 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY American Univ.			
13a. STATE New Jersey				13b. COUNTY Warren		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 1, Roaring Road			
14. FATHER'S NAME FIRST Kenneth MIDDLE T. LAST Cunningham				15. MOTHER'S MAIDEN NAME FIRST Gloria MIDDLE Sword LAST Sword									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 156-44-6618		17. INFORMANT ADDRESS Same as Kenneth T. Cunningham (father) - 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:40xx 5-3- 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Occupant of auto/auto collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET 9540 River Rd., CITY OR TOWN Potomac, COUNTY Montgomery, STATE MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 5-3-86					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6 May 86		23c. NAME OF CEMETERY OR CREMATORY Northampton Memorial Shrine				23d. LOCATION CITY OR TOWN Easton, COUNTY Penna. STATE			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA				ADDRESS				25a. DATE REC'D. BY REGISTRAR MAY 12 1986		25b. REGISTRAR'S SIGNATURE 			



00-07931

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation/transit. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 0 6

REG. NO.

1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Ruth E. Darmody			5 20 86			8 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			Caucasian			9 29 16			69 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			U.S.A.						Montgomery MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			110 Whitmoor Terrace			Homemaker					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Montgomery			Silver Spring			YES NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE					
Ludwig Schorr			Wilhelmina Snyder			110 Whitmoor Terrace 20901					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			577-09-4147			Son Portland, Oregon 97205			Lawrence J. Darmody 2020 S.W. Main #606		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cancer of pancreas						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)								
DUE TO, OR AS A CONSEQUENCE OF			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			Colon Cancer								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (a) (this hospital) attended the deceased from saw the deceased physician on 4/25 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated			4/25 1986			11/10 1986			5/20 1986		
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
Peter Sherer			MD			5/20/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Peter Sherer MD			3947 Ferrara Dr. Wheaton, MD 20906								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			May 23, 1986			Gate of Heaven Cemetery Silver Spring			Montgomery Md.		
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.			MAY 28 1986								

BP



00-07279

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

 DHMH - 16 60M 7/84
 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		20. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		21. DATE OF DEATH				2b. HOUR			
FIRST RICHARD MIDDLE ERNEST LAST DAVENPORT		5 12 86				4 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		5 12 86		YRS		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		NONE		NONE			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS - ZIP CODE			
MARYLAND		ELK RIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7808 BUTTERFIELD, DR. 21227			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		17. INFORMANT ADDRESS					
FIRST RICHARD MIDDLE G. LAST DAVENPORT		FIRST CHRISTINE MIDDLE E LAST SMITH		RICHARD G. DAVENPORT, FATHER, SAME AS ITEM 13					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		NONE		RICHARD G. DAVENPORT, FATHER, SAME AS ITEM 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Birth Asphyxia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Extreme lung immaturity									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Extreme prematurity									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY OFFICE FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19_____, 19_____, that (I) (we) lost									
saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Georgis G. Kefale M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Georgis G. Kefale									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
CREMATION		5/14/86		METROPOLITAN CREMATORY		ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
RICHARD RAPP, INC.		MAY 19 1986		Julia Davidson Rapp					
NAME		ADDRESS							
1804 T ST., N.W., WASHINGTON, D.C. 20009									

BP

00-060861

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614808
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cushman Kellogg Davis			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1986		2b. HOUR 3:33 a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 24, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Grain
13a. STATE Minnesota	13b. COUNTY St. Louis Co.	13c. CITY OR TOWN Duluth	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1820 Jefferson St. 55812	
14. FATHER'S NAME FIRST MIDDLE LAST William N. Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Ann Hansen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 476-05-8793A		17. INFORMANT ADDRESS Electa D. Ney (Sister) 1023 Woodside Pkwy. Silver Spring, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Accident		16 hours
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1986, to May 5, 1986, that (I) (we) last saw the deceased alive on May 4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Phillip Poth</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Phillip Poth, M.D.		22e. ADDRESS 831 University Blvd. Silver Spring, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Duluth, St. Louis Co. Minnesota
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 9 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14809

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES S. DAVIES		2a. DATE OF DEATH MONTH DAY YEAR 5-13-86		2b. HOUR 4 A.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 09 00		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shurckan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD	13b. COUNTY Montg.	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4920 Earlston Drive/20816	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Scheele		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice --- Boyle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-36-7156		17. INFORMANT ADDRESS Harry F. Davies, Bethesda, MD 20816	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 2 days 5 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Extensive metastatic disease of breast					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) Marvin Wadler attended the deceased from MAY 12 1986 to MAY 13 1986 , that (1) was last seen the deceased alive on MAY 12 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (2) was not view the body after death.					
22b. SIGNATURE Marvin Wadler		DEGREE M.D.		22c. DATE SIGNED 5/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER		22e. ADDRESS 8218 Wisconsin Av. Beth. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/16/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. DATE REC'D. BY REGISTRAR MAY 16 1986			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		25. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			
5130 Wisconsin Ave, NW, Washington, D.C. 20016					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please attach the permit to the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

Page

Number

Subject

Office

X

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Administrative

X

General

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Director

Adviser

1

Subject

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00-08762

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROOSEVELT DAWSON, JR.			2a. DATE OF DEATH MONTH DAY YEAR MAY 29 1986			2b. HOUR P M 7:06			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 17 1936		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S.A.F.		12b. KIND OF BUSINESS OR INDUSTRY DEFENSE	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5709 GYNNDAL PLACE 20735	
14. FATHER'S NAME FIRST MIDDLE LAST ROOSEVELT DAWSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILLIE MAE HARPER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954-1986		17. INFORMANT ERMA F. DAWSON		17. ADDRESS 5709 GYNNDAL PLACE, CLINTON, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY ATHEROSCLEROTIC DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1</u> 19 <u>86</u> to <u>MAY 29</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 29</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles K. Lee</i>				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. K. LEE, CDR, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/86		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JUN 8 1986			
6633 Old Alexander Ferry Rd. Clinton, MD. 20735				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-06950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14811

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Helen</u> MIDDLE <u>B.</u> LAST <u>Day</u>		2a. DATE KNOWN OF DEATH MONTH <u>10</u> DAY <u>14</u> YEAR <u>1986</u>		2b. HOUR <u>7:02</u> PM	
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>Feb</u> DAY <u>26</u> YEAR <u>1980</u>	6. AGE (IN YEARS) LAST BIRTHDAY <u>6</u> YRS.	IF UNDER 1 YR. MONTHS <u>7</u> DAYS <u>1</u>	IF UNDER 24 HRS. HOURS <u>1</u> MIN. <u>00</u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. DATE PRONOUNCED DEAD MONTH <u>May</u> DAY <u>14</u> YEAR <u>1986</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD.</u>			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Ho Y Crows Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>English Teacher</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>County School</u>		13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>	
13c. CITY OR TOWN <u>20910</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>9030 Altan Hwy.</u>	
14. FATHER'S NAME FIRST <u>Cronin</u> MIDDLE <u>Mackendree</u> LAST <u>Burdette</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Lolita</u> MIDDLE <u>Young</u> LAST <u>Young</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>219-36-7631</u>		17. INFORMANT ADDRESS <u>James K. Day, Item 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Chronic Myocardial Dis.</u> (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>None</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		TITLE (SPECIFY) <u>Dep.</u>		MEDICAL EXAMINER DATE SIGNED <u>May 14, 1986</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers, M.D.</u>		ADDRESS <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>May 15, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westview</u>	
23d. LOCATION CITY OR TOWN <u>Baltimore, Maryland</u>		COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>Olin L. Molesworth, P.A., Damascus, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 19 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14812

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
Randy E. Butler		5/30/1986		8:50 P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. CITIZEN OF WHAT COUNTRY?	8. MARRIED
Male	Black	MONTH DAY YEAR	LAST BIRTHDAY	U.S.A.	<input checked="" type="checkbox"/> NEVER MARRIED
			YRS. MONTHS DAYS HOURS MIN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		
Washington, D.C.	Montgomery County, MD.		Silver Spring		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Holy Cross Hospital		None		None	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
M.D.		Montgomery		Wheaton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		None	
Randolph		Veronica Deans			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
(YES, NO, OR UNKNOWN)		ADDRESS		PART I DEATH WAS CAUSED BY:	
No		12232 Center Hill St. Wheaton, Maryland 20902		IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b)	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
TITLE (SPECIFY)					
M.D. Assistant MEDICAL EXAMINER					
DATE SIGNED 5/31/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					
Burial					
23b. DATE					
6/3/86					
23c. NAME OF CEMETERY OR CREMATORY					
Harmony Memorial Park					
23d. LOCATION					
Landover Prince George's MD					
24. FUNERAL DIRECTOR					
ROLLINS FUNERAL HOME, INC.					
4339 HUNT PLACE, N.E.					
WASHINGTON, D.C. 20019					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6 1 4 8 1 3				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE (NMN) DECKMAN					2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1986			2b. HOUR 8:15A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 14, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Howard CoGen'l Hosp.			
13a. STATE MARYLAND		13b. COUNTY Howard		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5404 STORM DRIFT 21045	
14. FATHER'S NAME FIRST MIDDLE LAST Angelo Peter Polito				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 067-34-5872		17. INFORMANT (HUSBAND) ADDRESS BERNARD M. DECKMAN SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse undifferentiated lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he) (this hospital) attended the deceased from April 11, 19 86, to MAY 28, 19 86, that (he) (we) last saw the deceased alive on MAY 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Witzke</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LASSON, Norman				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20894					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 31 '86		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard Maryland			
24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home Inc 4112 Old Columbia Pike Ellicott City				25. REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14814

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED		2b. DATE PRONOUNCED DEAD		2c. DATE KNOWN OF DEATH ESTIMATED		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
RAY		Male		White		December 13, 1948		37 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
East Africa		United States				Montgomery County		1:30 PM	
11. CITY OR TOWN OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
Bethesda		Production Control		Electronics		Maryland		Montgomery	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Milan		Alice Ekanger		No		566-76-8029		Alice E. deLany 4970 Battery Lane Bethesda, Maryland 20814 (Mother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple drug intoxication						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5-15 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
				Subject ingested drugs.				Home	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE			
4970 Battery Lane,		Bethesda,		Montg.		Md.			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		M.D. Assistant		MEDICAL EXAMINER	
Ann M. Dixon, M.D.		111 Penn St., Balto., MD		21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY	
Cremation		May 17, 1986		Metropolitan Crematory		Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes PA		MAY 21 1986		Julia Davidson					
7557 Wisconsin Avenue Bethesda, Maryland 20814									

DIVISION OF VITAL RECORDS, 301 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND PAGE 5 WITH PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8614815	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) George A. DePaul					2a. DATE OF DEATH MONTH DAY YEAR 5 15 86 2b. HOUR 0214 M						
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 12 1920			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Panama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Private Club			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8201 16th Street 20910			
14. FATHER'S NAME FIRST MIDDLE LAST Information not available					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda E. Paul						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 18 3772		17. INFORMANT 11200 Lockwood Drive Silver Spring Md. 20901							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive upper and lower G-I Bleeding DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Esophageal varices, End stage liver disease and Coagulation defect (c) End stage liver disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hepatic encephalopathy.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/14/86, 1986, to 5/15/86, 1986 that (I) (we) lost saw the deceased alive on 5/14/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. A. Chacko				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. A. CHACKO				22e. ADDRESS 8500, 16th St. suite G31 Silver Spring MD 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 27 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR McGuire Funeral Service				7400 Georgia Ave. Washington D.C.				25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 · 14816

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID E. DE ROSE			2a. DATE OF DEATH MONTH DAY YEAR 5-7-86			2b. HOUR 1:00 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 4, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY PAINTING			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			13e. STREET ADDRESS / ZIP CODE 2601 BEL PRE ROAD 20906			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT ADDRESS HEIGHTS, MD. 20743		CHARLOTTE ALONSO, DAUGHTER, 303 ADDISON RD. S., CAPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA TO BRAIN 6 MO</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNKNOWN PRIMARY ADENOCARCINOMA 6 MO</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>FLUID + ELECTROLYTE IMBALANCE</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 (PART 1) OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> 19 <u>86</u> to <u>5-7</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard P. Delaney</u>						DEGREE MEDICAL		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.						22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/9/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009						25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

13880-00



00-08327

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please retain on your papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE DE YOUNG		2a. DATE OF DEATH MONTH DAY YEAR 5 26 86		2b. HOUR 10 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 11 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5205 Carlton Street 20816	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert J. Cronin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anastasia L. Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 11 579-66-0410	17. INFORMANT ADDRESS David F. De Young-husband-(same as 13 e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerna Hepatic liver failure. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the liver. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 wks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Saundice Ascaris.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/19/86 to 5/25/86 that (I) (we) last saw the deceased alive on 5/24/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S.B. Goswami MD		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.B. GOSWAMI MD		22e. ADDRESS 5401 Greenstone St. Charlotte MD 28215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-30-1986	23c. NAME OF CEMETERY OR CREMATORY Quantico National		23d. LOCATION CITY OR TOWN COUNTY STATE Quantico Virginia	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUN 3 1986	25b. REGISTRAR'S SIGNATURE [Signature]

BP

RECEIVED
SECTION 200

11/10/17



00-04289


DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 14818

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
VINCENT		4 18 1986		M	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		4 29 1929	
6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
56		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Pennsylvania		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Takoma Park		Washington Adventist Hosp.		School Teacher	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland		Prince Georges Beltsville		13207 Ingleside Drive 20705	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Marco		DiBiase		173-22-7639	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Brother) ADDRESS	
yes		Korean Conflict		Anthony DiBiase- 8713 Deanna Drive Gaithersburg, Md. 20879	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute asthma</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE 		M.D. Assistant		4-18-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-21-1986		Fort Lincoln Cemetery	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF REGISTRATION	
Hines/Rinaldi Funeral Home		11800 N. H. Ave., Silver Spring, Md.		APR 22 1986	
				25b. REGISTRAR'S SIGNATURE	

7

00-08204

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14819
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAY DISPENZA			2a. DATE OF DEATH MONTH DAY YEAR 5/30/86		2b. HOUR PM 11
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 23, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kitchen Assistant		12b. KIND OF BUSINESS OR INDUSTRY Public School
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. STREET ADDRESS / ZIP CODE 4521 East West Highway 20814		
14. FATHER'S NAME FIRST MIDDLE LAST Augustino Dispenza		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Arena			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT (Brother) ADDRESS Frank Dispenza 534 Ocean Pines Berlin, Maryland 21811			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF OVARY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 WK
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 5/16/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF OVARY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from MAY 4, 1986, to MAY 30, 1986, that (we) last saw the deceased alive on MAY 30, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ralph Coan		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/31/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH COAN M.D.		22e. ADDRESS 4400 EAST WEST HWY. BETHESDA, Md - 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 3, 1986	23c. NAME OF CEMETERY OR CREMATORY St Mary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A. 7557 Wisconsin Avenue, Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR JUN 2 1986		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirements for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

00-06451

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

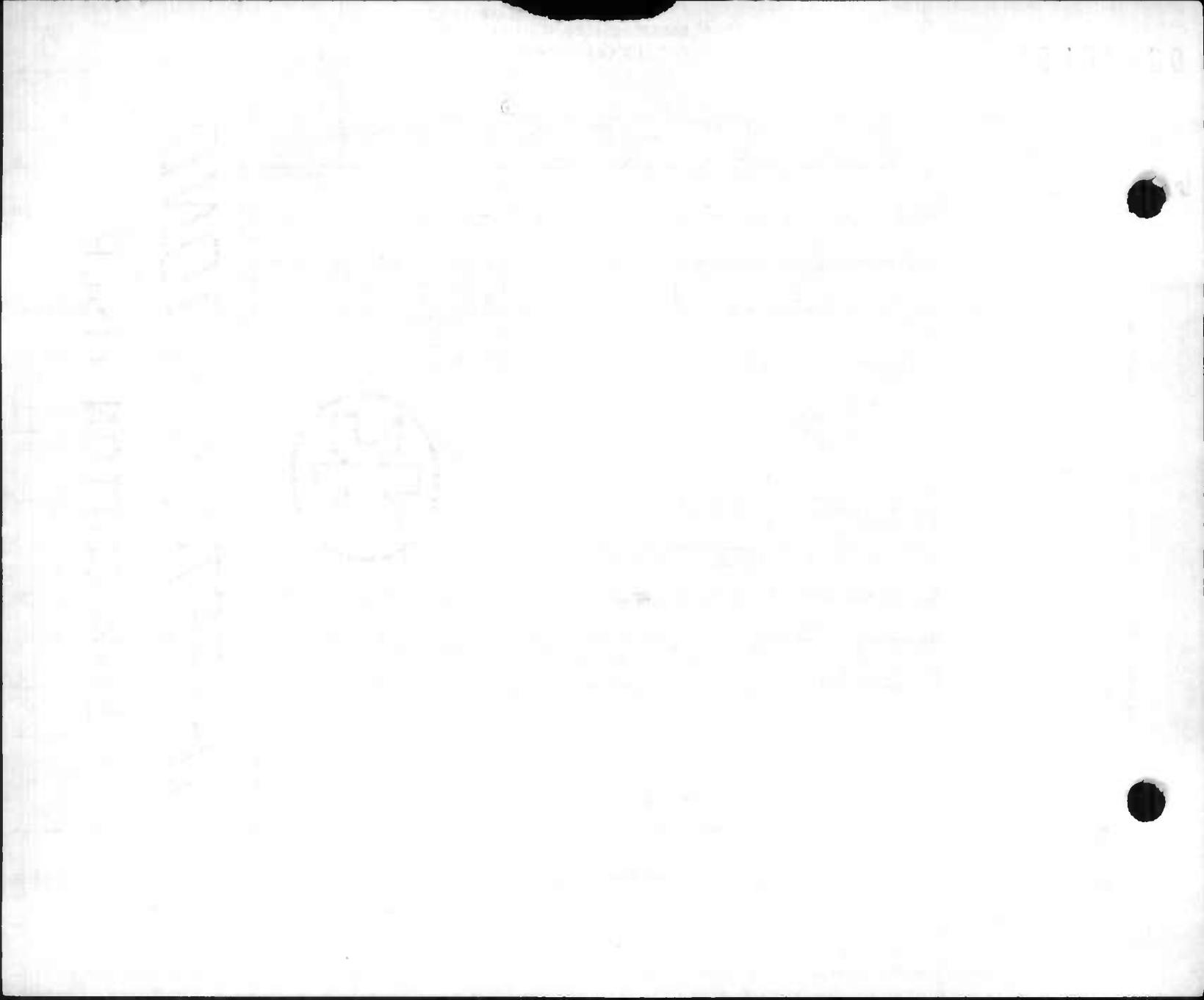
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10A. 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6										REG. NO. 1 4 8 2 0	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Si Tuau Do										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5/ 5/ 19 86	
2b. HOUR M										2c. DATE PRONOUNCED DEAD 5/ 5/ 19 86	
3. SEX Male										2d. HOUR 8:03	
4. RACE Vietnamese										2e. P M	
5. DATE OF BIRTH Sept. 15, 1950											
6. AGE (IN YEARS) 35											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vietnam											
7b. CITIZEN OF WHAT COUNTRY? U.S.A.											
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD											
10. CITY OR TOWN OF DEATH Gaithersburg											
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18573 Mountain Laurel Terrace											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Draftsman/Designer											
12b. KIND OF BUSINESS Lobederman Associates											
13a. STATE Maryland											
13b. COUNTY Montgomery											
13c. CITY OR TOWN Gaithersburg											
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
13e. STREET ADDRESS 18573 Mountain Laurel Terrace											
14. FATHER'S NAME Man											
15. MOTHER'S MAIDEN NAME Kim Cuc Do											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No											
16b. SOCIAL SECURITY NO. 220-58-8236											
17. INFORMANT Kim Do - sister, 407 Patrick Lane, Herndon											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound to Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M. 5/ 5/ 19 86											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home											
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 18573 Mountain Laurel Ter., Gaithersburg, Md.											
22a. I certify that I took charge of the remains described above and that the autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Gregory R. Kauffman, M.D. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 5/6/86											
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL Burial											
23b. DATE 5/8/86											
23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cemetery											
23d. LOCATION CITY OR TOWN COUNTY STATE Herndon Fairfax VA											
24. FUNERAL DIRECTOR J. Berkley Green, Herndon, Virginia											
25a. DATE RECD. BY REGISTRAR MAY 18 1986 REGISTRAR SIGNATURE											

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



00-06808

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other thing, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

14821

1. DECEASED NAME (TYPE OR PRINT) SYLVIA M. DOERNER			2a. DATE OF DEATH MONTH 5 DAY 10 YEAR 86		2b. HOUR 1 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 5 DAY 15 YEAR 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC DAWG		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -
13a. STATE MD	13b. COUNTY MONT	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS - ZIP CODE 1235 Potomac Valley Rd 20850	
14. FATHER'S NAME Warren MIDDLE Wilson		15. MOTHER'S MAIDEN NAME Alice MIDDLE Chisler LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 578-48-4819		17. INFORMANT Richard J. Doerner 703 Robert Road.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension cardiovascular disease				20+ year	
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Prostatic Carcinoma, benign, lobular, chronic, CTR					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-5 19 82 to 5-10 19 82 that (I) (we) lost saw the deceased alive on 5-5 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MD, Celsus		DEGREE M.D.		22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN ROSA, MD		22e. ADDRESS 1722 REDLAND RD DENVILLE MD 20855			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 5/13/86	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland	
24. FUNERAL DIRECTOR Wheeler Funeral Home, Inc.		25a. DATE RECD BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
1331 Rockville Pike, Rockville, Md. 20852					



00-07685

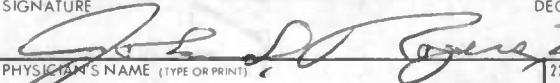
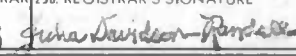
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 14822	
FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martinia A. Donaldson						2a. DATE OF DEATH MONTH DAY YEAR May 22, 1986		2b. HOUR 2:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION; (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19137 Willow Grove Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN OLNEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19137 Willow Grove Road 20832			
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR - HENION				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE - TALMADGE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-46-2174		17. INFORMANT ADDRESS ALFRED L. DONALDSON, JR. SAME AS # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR XXXXX May 12, 1986 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1919 Seminary Road Silver Spring, Montgomery County, Md.							
22a. I certify that (I) (the deceased) attended the deceased from XXXXX May 12, 1986 to May 19, 1986 , that (I) (X) (e) last saw the deceased alive on XXXXX May 12, 1986 , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (X) (did not) view the body after death.										22c. DATE SIGNED 5/22/86	
22b. SIGNATURE 				DEGREE MD				22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE MAY 27, 1986		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT. MD.					
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D. BY REGISTRAR MAY 27 1986		25b. REGISTRAR'S SIGNATURE 			

00-08488

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614823

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		FREDERIC WATTS DONOUR, SR.					MAY 27, 1986					9:10p M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS		
MALE	WHITE	JUNE 28, 1918		67 YRS		MONTGOMERY COUNTY MD.		MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ALABAMA	U.S.A.					BETHESDA		NIH, THE CLINICAL CENTER		PIPE FITTER		WELDING
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME
ILLINOIS		ST. CLAIR		BELLEVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 ELMWOOD DRIVE 62220		JAMES		LELA
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES		494-10-7266		FREDERIC W. DONOUR, JR.		VENTRICULAR FIBRILLATION		MAY 27, 1986		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
WWII				VA BEACH, VA 23462		DUE TO, OR AS A CONSEQUENCE OF		RENAL CELL CARCINOMA; DIABETES MELLITUS		5/29/86		
						(b) ACUTE MYOCARDIAL INFARCTION				15 HOURS		
						(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
RENAL CELL CARCINOMA; DIABETES MELLITUS												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		22c. DATE SIGNED
		HOUR A.M. MONTH DAY YEAR				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE		5/29/86
		P.M. 19										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 16, 1986, to MAY 27, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 27, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		
Joseph M. Reilly MD						5/29/86		JOSEPH Reilly		NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION		24. FUNERAL DIRECTOR
CREMATION		5/29/86		METROPOLITAN CREMATORY		ALEXANDRIA, VIRGINIA		METROPOLITAN CREMATORY		ALEXANDRIA, VIRGINIA		RICHARD RAPP, INC.
												1804 T ST., N.W., WASHINGTON, D.C. 20009
												25a. DATE REC'D. BY REGISTRAR
												JUN 4 1986
												25b. REGISTRAR'S SIGNATURE
												John Davidson-Henderson

00-05979

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 2 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD BENJAMIN DOUPE'			2a DATE OF DEATH MONTH DAY YEAR May 2 1986		2b HOUR 4 P M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR January 18 1905		6 AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9701 Fields Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Marine	12b KIND OF BUSINESS OR INDUSTRY Merchant Marine	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Henry Doupe'		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Flaherty		13e STREET ADDRESS / ZIP CODE 9701 Fields Road, Apt. 1002 20878	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 125-03-5721		17. INFORMANT ADDRESS Frances M. Morris 9701 Fields Road, Apt. 1002 Gaithersburg, Md. 20878	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) IDEOPATITIC PULMONARY FIBROSIS DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from March 84 to April 2 19 86 that (I) (we) last saw the deceased alive on April 2 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.					
22b SIGNATURE Alan S. Chanale		DEGREE MD		22c. DATE SIGNED 5/5/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALAN CHANALES		22e ADDRESS 9410 OLD GEORGETOWN RD, BETHESDA, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 6, 1986		23c NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE (Queens County) East Elmhurst, New York		23e DATE REC'D. BY REGISTRAR MAY 8 1986			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY		25 REGISTRAR'S SIGNATURE Julia Davidson			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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00-06478

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles H. Draper			2a. DATE OF DEATH MONTH DAY YEAR 5 / 7 / 86		2b. HOUR 10 25 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH July 16, 1900	6. AGE (IN YEARS (LAST BIRTHDAY)) 85	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION National Lutheran Home		12a. USUAL OCCUPATION Bookkeeper-American Security Bank	12b. KIND OF BUSINESS OR US	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland	13b. CITY Montgomery	13c. STATE Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9701 Viers Drive 20850	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert L. Draper	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Taylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Wife: Grace M. Draper same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>arteriosclerotic Heart Disease with Congestive Heart Failure</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (myself) attended the deceased from <u>April 17</u> , 19 <u>86</u> , to <u>May 7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>May 7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Harold F. McCann</u>	DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>5-7-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD F. MCCANN</u>		22e. ADDRESS <u>4362-26th St. N. Arlington Va. 22207</u>			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE <u>May 10, 1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens Cemetery</u>	23d. LOCATION <u>Arlington, Va.</u>		
24. FUNERAL DIRECTOR NAME <u>Ives-Pearson Funeral Homes</u> <u>Falls Church, Va. 22046</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 12 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julie Brindley</u>	

BP

00-07367

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 14826

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
RITA C. DUFFIELD		5 14 19 86		A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Fe	C	7 7 10	75 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	8. WIDOWED	8. DIVORCED
Washington, D.C.	USA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	9. BALTIMORE CITY OR COUNTY OF DEATH	
KENSINGTON	10225 KENSINGTON PKWY	Secretary	U.S. Gov't.	MONTGOMERY MD	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	13f. ZIP CODE
MD	MONTGOMERY	KENSINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10225 KENSINGTON PKWY	20895
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Unknown	Unknown	No			
16b. SOCIAL SECURITY NO.	17. INFORMANT	17. ADDRESS			
577-34-0239	John E. Walsh	4315 Joplin Drive Rockville, Maryland 20853			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					ACUTE
DUE TO, OR AS A CONSEQUENCE OF					
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					DEF
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		5 14 19 86		FOUND ON COUCH IN LIVING ROOM	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		Home		10225 KENSINGTON PKWY KENSINGTON MONTGOMERY MD	
22a. I certify that I took charge of the remains described above, held on death resulted from:					
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Francis J. Collins, Jr.		DEPT		5/17/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins, Jr.		8200 Wisconsin Ave Bethesda MD		MAY 22 1986	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	May 20, 1986	Gate of Heaven Cemetery	Silver Spring	Montgomery	Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins, Jr.		MAY 22 1986		MAY 22 1986	
500 University Blvd., W. Silver Spring, Md.					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 7/76

100-0-1

100-0-1

100-0-1



00-084-17

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614827

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BAHIA ELBABA		2a. DATE OF DEATH MONTH DAY YEAR 5-30-86		2b. HOUR 12:35 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3-29-06		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Palestine	7b. CITIZEN OF WHAT COUNTRY? Jordan	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Habib Souri		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Latifa Yankey		13e. STREET ADDRESS / ZIP CODE 10114 Haywood Drive 20902	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-64-8658		17. INFORMANT ADDRESS Lourice Parisr Daughter Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS 2 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 83 , to MAY 86 , that (I) (we) last saw the deceased alive on MAY 30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert L. Rosenberg, MD		DEGREE MD		22c. DATE SIGNED 5-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD		22e. ADDRESS 10313 GEORGIA AVE, SILVER SPRING, MD 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR'S NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers	
500 University Blvd., W. Silver Spring, Md.					

STATIONER
1000 W. BROADWAY
CHICAGO, ILL.

Estimate from Chicago
Chicago from Chicago
Chicago from Chicago
Chicago from Chicago

Robert L. Robinson
Chicago, Ill.
Dec 22 1942
X
2-10-43

JUN 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14828

1. DECEASED NAME (TYPE OR PRINT) LOIS F. ENGEL										2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 13 1986		2b. HOUR MIN. AM 1:25 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Dec 30 1901		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 84 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 13 1986		2d. HOUR MIN. AM 1:25 PM			
7a. BIRTHPLACE (STATE OR COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Tak Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp.				12a. USUAL OCCUPATION (TYPE OR WORK) EXECUTIVE SOCIAL WORKER				12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.					
13a. STATE MD										13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20903 1066 Rutland St	
14. FATHER'S NAME ABRAHAM				MIDDLE FINKELSTEIN				15. MOTHER'S MAIDEN NAME JULIA				MIDDLE KAHN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 111-14-9185				17. INFORMANT JOSEPH ENGEL, 1066 RUATAN STREET, SILVER SPRING, MARYLAND									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE DR. JOHN S. ROGERS, M. D.				TITLE (SPECIFY) Dep.				MEDICAL EXAMINER 1919 SEMINARY ROAD				DATE SIGNED May 13 1986					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS SILVER SPRING, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 5/15/1986				23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY				23d. LOCATION (CITY OR TOWN) COUNTY STATE ADELPHI, GEORGE'S, MARYLAND					
24. DONOR DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME								25a. DATE REC'D. BY REGISTRAR MAY 19 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodwell					
26. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

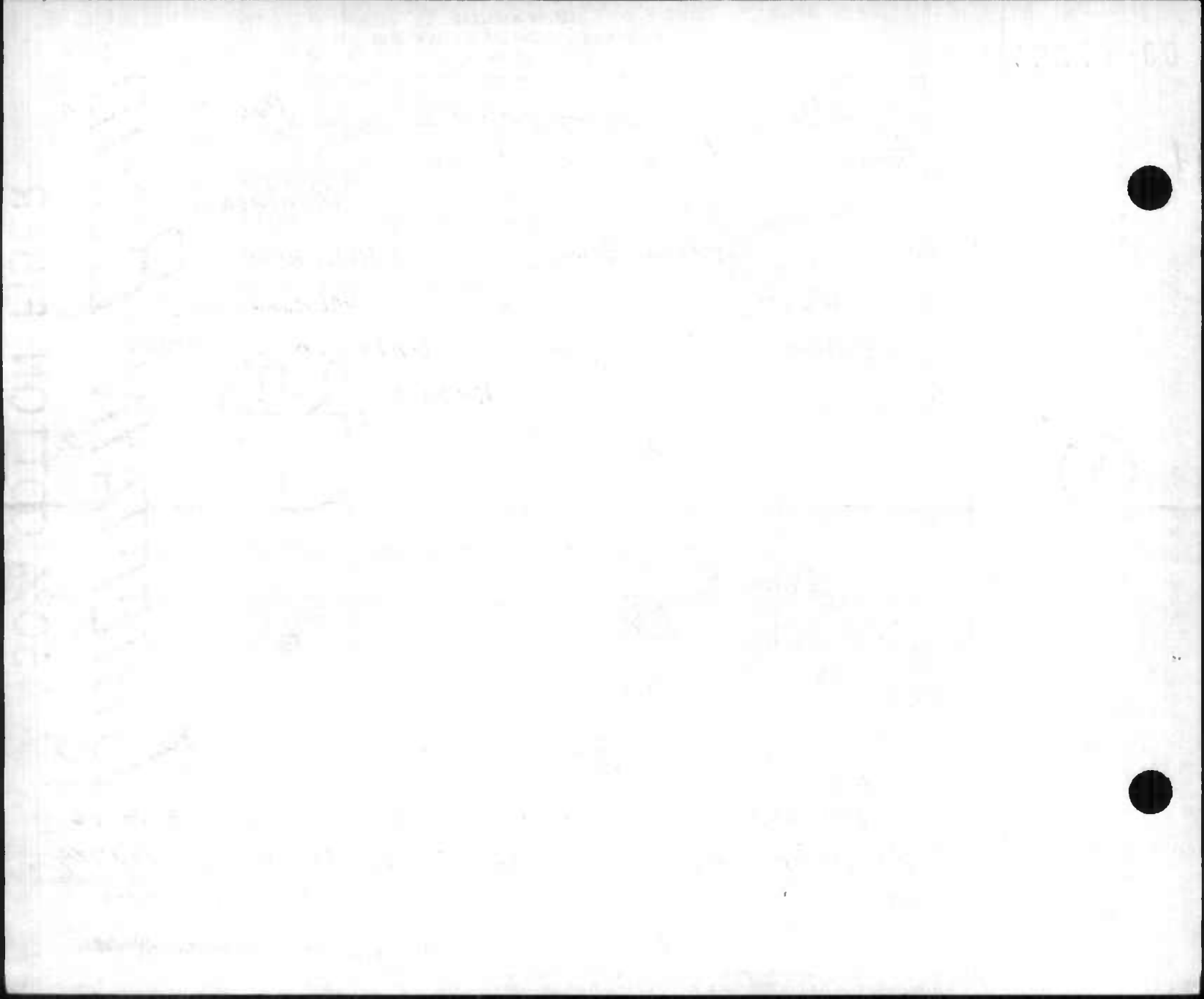
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 2 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETA Epstein		2a. DATE OF DEATH MONTH DAY YEAR May 19 1986		2b. HOUR 6 30 A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 17 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY Mont	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST LAST Sam Bromberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Silverstein		13e. STREET ADDRESS / ZIP CODE 605 Montrose Rd. 20852	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Husband: Morris Epstein same as #13	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia					
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED X		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 3/19/86 to 5/19/86 and that (2) my opinion of death occurred on the date and hour and from the causes stated above, (1) was not influenced by any other person, and (2) I did not view the body after death.					
22b. SIGNATURE Raymond Bass		DEGREE MD		22c. DATE SIGNED 5-19-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS		22e. ADDRESS 394 Ferriera Dr Wheaton Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1986		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Pk.	
23d. LOCATION Falls Church, Virginia		23e. DATE REC'D BY REGISTRAR MAY 21, 1986			
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va. 22046		25. REGISTRAR'S SIGNATURE John Davidson			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 1 4 8 3 0 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
John ERIKSSON		05 08 86		6 ⁰⁰ P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		WHITE		JUNE 28, 1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
SWEDEN		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ROCKVILLE		Shady Grove Adventist Hospital		SUPT.	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		X NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
MILS		ERIKSSON		KAREN	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)	
NO		578-01-1218		REV. DR. RICHARD REICHARD-NIH-ROCKVILLE	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1988, to May 8, 1988, that (I) (we) lost saw the deceased alive on May 7, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death		22b. SIGNATURE Thomas E. Dooley, M.D.		22c. ADDRESS 11904 Georgia Avenue Olney, Maryland 20832	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MAY 13, 1986		CEDAR HILL CEM.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
HYSONG CO., INC.-1300 N STREET, WASH., DC				MAY 22 1986	
25b. REGISTRAR'S SIGNATURE		25c. DATE		25d. REGISTRAR'S SIGNATURE	
John Davidson-Randall				John Davidson-Randall	

ERIKSSON

00-01260



00-06033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

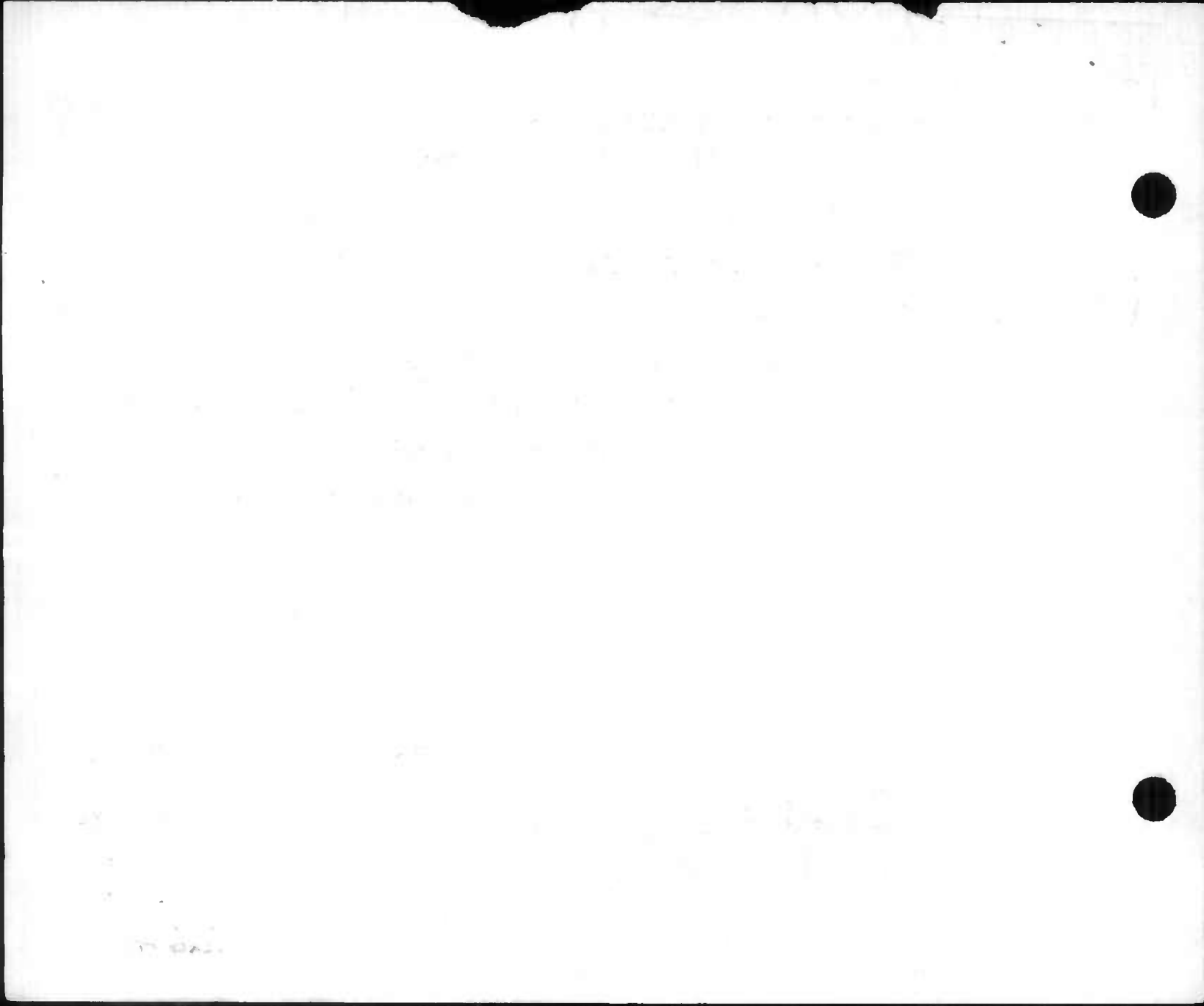
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sister Mary Angels, Mary Estelle Everett		2a. DATE OF DEATH MONTH 5 DAY 1 YEAR 86		2b. HOUR 9 15 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 7 DAY 5 YEAR 1893		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Kensington, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Angela Hall	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Religious Nun		12b. KIND OF BUSINESS OR INDUSTRY Teacher	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5000 Strathmore Avenue 20895	
14. FATHER'S NAME FIRST Louis MIDDLE A. LAST Everett		15. MOTHER'S MAIDEN NAME FIRST Mary Elizabeth MIDDLE Raley LAST Raley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-66-5561		17. INFORMANT Superior Sister Catherine Lash ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-30 19 86 to 5-1 19 86 , that (I) (we) last saw the deceased alive on 4-30 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald R Bucy		DEGREE MD		22c. DATE SIGNED 5-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L Bucy		22e. ADDRESS 809 Veris mill Rd Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION CITY OR TOWN Washington, D. C.		COUNTY D.C.		STATE D.C.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25. DATE RECEIVED BY REGISTRAR MAY 8 1986			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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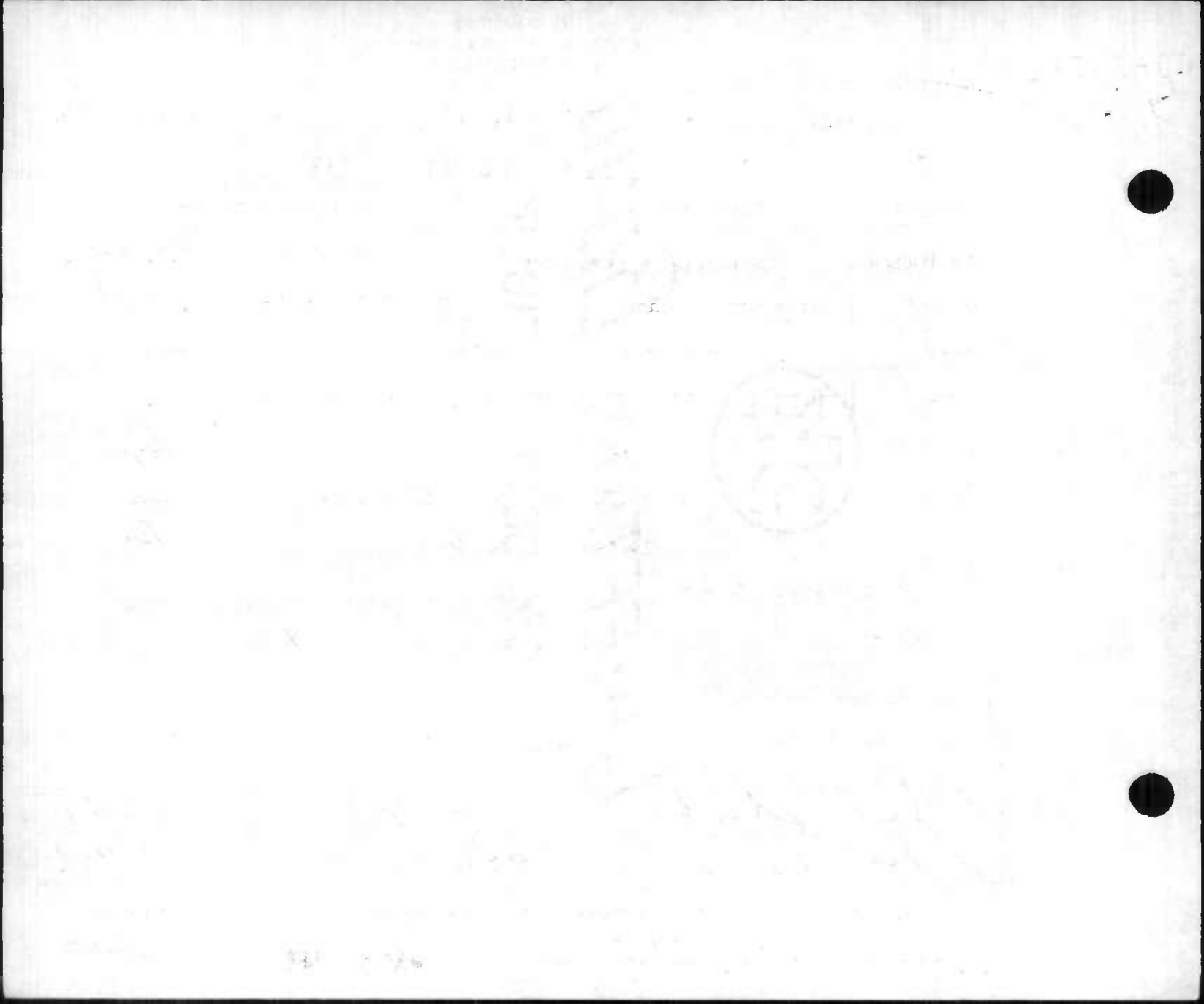
1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William H. Everhardy			2a. DATE OF DEATH MONTH DAY YEAR 05 02 86			2b. HOUR 12²² AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 12 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Translator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5810 Bradley Blvd. 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob L. Everhardy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Hesse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Irene B. Everhardy		ADDRESS Same as # 13e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebro-vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None None None	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Respiratory Failure										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9410 Old Georgetown Rd Bethesda 20814					
22a. I certify that (I) (this hospital) attended the deceased from 5/1/86 to 5/1/86 , that (I) (we) lost saw the deceased alive on 5/1/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/2/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. C. Schyler			22e. ADDRESS 9410 Old Georgetown Rd Bethesda 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes						25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE [Signature]		
P.A. 7557 Wisconsin Ave. Bethesda, Maryland										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-08518

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

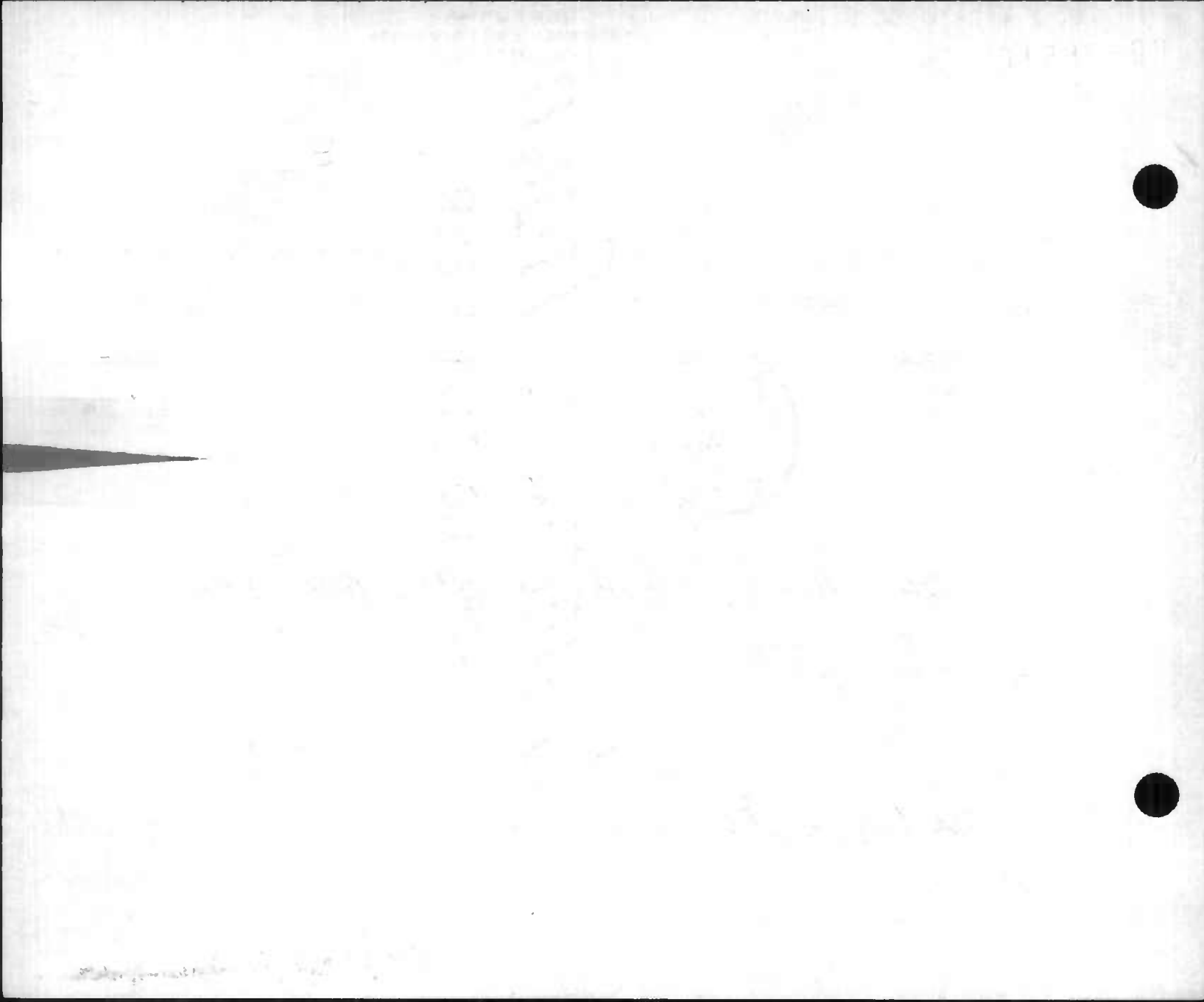
86 REG. NO. 14833

1. DECEASED NAME (TYPE OR PRINT) Max Falik		2a. DATE OF DEATH MONTH DAY YEAR 5 18 86		2b. HOUR 11:50 A	
3. SEX M	4. RACE C 1	5. DATE OF BIRTH MONTH DAY YEAR 2 21 07		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF FIRST IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10050 Counselman Road 20839
14. FATHER'S NAME FIRST MIDDLE LAST Peretz unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Selma unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 089 01 3582		17. INFORMANT ADDRESS Miriam Falik(wife) See # 13 above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>VENTRICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ISCHEMIC CARDIO MYOPATHY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPERTENSIVE ASCVD, SICK SINUS SYNDROME & PACEMAKER</u>			
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1981</u> , 19 <u>81</u> , to <u>MAY 14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>William C. Greene</u>		DEGREE NO	22c. DATE SIGNED MAY 18, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 20 1986	23c. NAME OF CEMETERY OR CREMATORY Judean Mem'l Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland
24. FUNERAL DIRECTOR NAME Ives-Pearson F. H. Falls Church, Virginia		25a. DATE REC'D. BY REGISTRAR MAY 23 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson



00-06329

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		6		14834		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie M. Farley					2a. DATE OF DEATH MONTH DAY YEAR May 12 1986			2b. HOUR 12:P. M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pre Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 705 Orchard Way 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Ries				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unobtainable Kottman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Francis J. Farley-son- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-2</u> , 19 <u>84</u> , to <u>5-11</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5-11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Christopher Unger MD</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, MD				22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson</u>	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

00-08352

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535



RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

00-086091

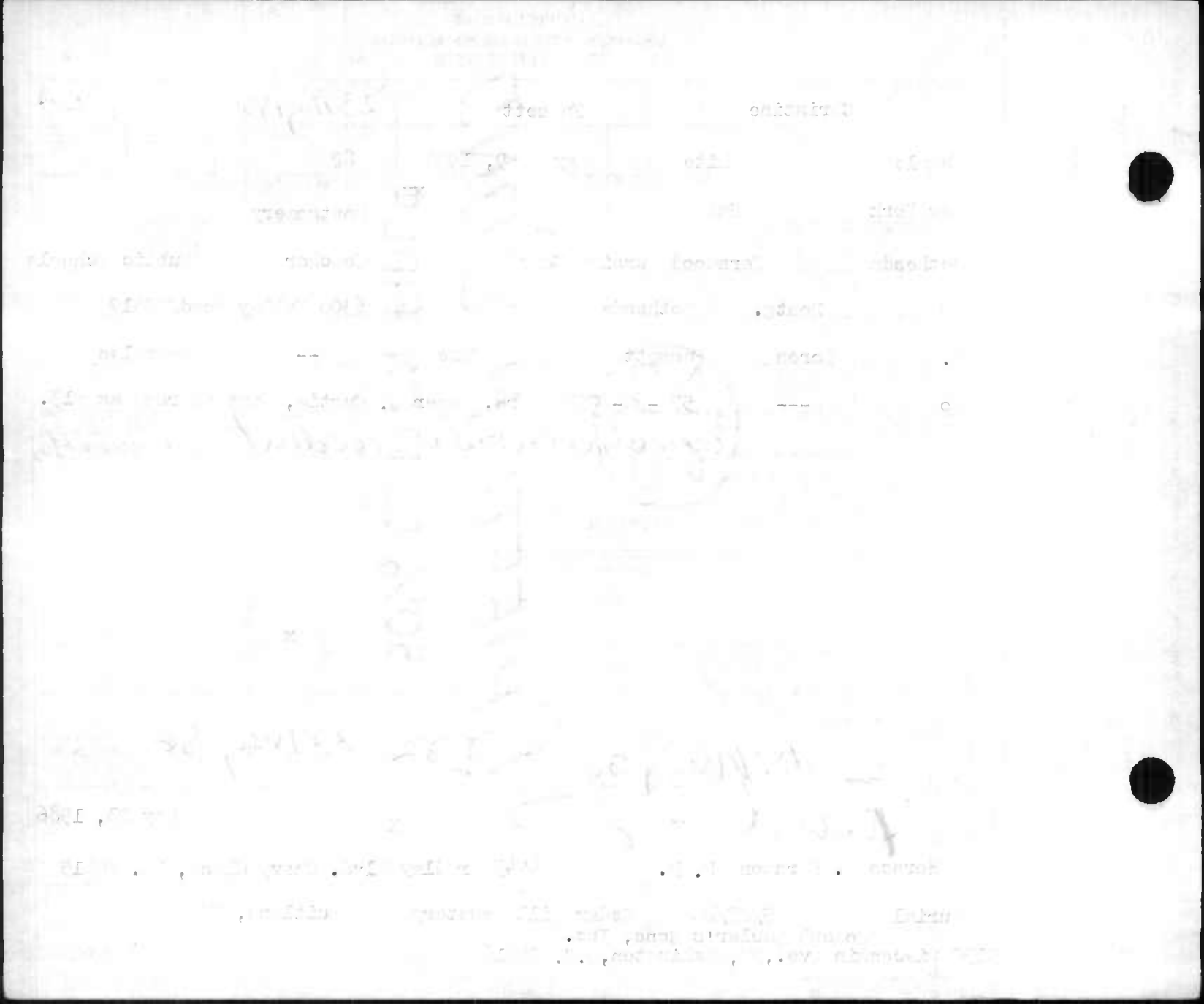
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 8 3 5

1. DECEASED NAME (TYPE OR PRINT) Christine Fassett			2a. DATE OF DEATH MONTH DAY YEAR 23 May 1986		2b. HOUR MIN. 5:47							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. 5:47		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools				
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6308 Valley Road/20817				
14. FATHER'S NAME FIRST MIDDLE LAST H. Loren Fassett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Reynolds								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Mrs. Roger W. Curtis, Same address as #13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1982 to 22 May 86 , that (I) (a) lost 1986 and that in (my) opinion death occurred on the date and hour and from the causes stated												
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton M. D.						22c. DATE SIGNED May 23, 1986						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 5/27/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR MAY 29 1986			25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>			



00-07003

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 3 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James J. Fayed			2a. DATE OF DEATH MONTH DAY YEAR 5-15-86		2b. HOUR 8 36 PM	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 10-20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Fayed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary O. Fayed			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 577-22-6477		17. INFORMANT Marion C. Fayed-wife- (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease					1 year	
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Medical Cardiac Arrest						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/15/86 to 5/15/86 that (I) (we) lost saw the deceased alive on 5/15/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED May 16, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz		22e. ADDRESS 11800 N.H. Ave. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-19-1986	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		
		25b. REGISTRAR'S SIGNATURE [Signature]				

BP

00-6500

1

00-06046

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a burial-transit permit from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14837
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE			2a. DATE OF DEATH MONTH DAY YEAR 05 04 86			2b. HOUR 12⁴⁵ M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 6, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK, AGO, MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN MONTGOMERY 13c. ZIP CODE ROCKVILLE							
14. FATHER'S NAME MORDECAI		15. MOTHER'S MAIDEN NAME (UNASCERTAINABLE)		16. STREET ADDRESS / ZIP CODE 6121 MONTROSE ROAD 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-62-6990		17. INFORMANT MELVIN B. FEIFER, 1023 NORA DRIVE SILVER SPRING, MARYLAND			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CONGESTIVE CARDIAC FAILURE**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1 MONTH**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **ISCHEMIC CARDIOMYOPATHY**

DUE TO, OR AS A CONSEQUENCE OF

(c) **-**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **-**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/3/81 to 5/4/86 that (I) (we) last saw the deceased alive on 5/4/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D.D. PATEL				DEGREE M.D.		22c. DATE SIGNED 5/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL				22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/6/1986		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR MAY 07 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	
232 CARROLL STREET, N. W., WASHINGTON, D. C.							

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0-05912

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 3 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID FEINBERG			2a. DATE OF DEATH MONTH DAY YEAR 5/4/86		2b. HOUR 200 A M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 15, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6105 MONTROSE ROAD 20852		
14. FATHER'S NAME FIRST MIDDLE LAST BARNET FEINBERG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-07-3563		17. INFORMANT ADDRESS DEERFIELD BEACH, FLORIDA BARNET FEINBERG, NEPHEW, 581 S.E. 15TH AVE.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		2 weeks
(b) severe congestive heart failure		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 26, 1986 to May 4, 1986 , that (I) (we) last saw the deceased alive on May 3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Mark Rosen	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/4/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen		22e. ADDRESS 3941 Ferrara Drive, Silver Spring, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/6/86	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI, PRINCE GEORGES, MD.
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009		25a. DATE REC'D. BY REGISTRAR MAY 7 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner will be notified of this.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614839
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucille S. Fellows			2a. DATE OF DEATH MONTH DAY YEAR 05 03 86			2b. HOUR 6:40 AM			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 05 03		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick C. Scheidecker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Andrews			16. STREET ADDRESS / ZIP CODE 316 Mt. Vernon Rockville, Md. 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Robt. Fellows Rockville, Md. 20850					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Subarachnoid Hemorrhage									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 6				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-2-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rockville					
22a. I certify that (I) (this hospital) attended the deceased from 5-2-86 to 5-2-86 , that (I) (we) last saw the deceased alive on 5-2-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Kelly		DEGREE John E. Kelly		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-3-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Kelly		22e. ADDRESS 9715 MEDICAL CENTER DR. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-4-86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR MAY 7 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

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00-06812

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charlotte Hamilton Ferris			2a. DATE OF DEATH MONTH DAY YEAR May 13, 1986			2b. HOUR 6:45 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5810 Cedar Parkway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5810 Cedar Parkway/20815	
14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Hamilton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie -- French						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I 216-46-2309		17. INFORMANT ADDRESS George M. Ferris, Same address as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis								5 Years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from September 1985 to May 13 1986 that (I) (we) last saw the deceased alive on May 12, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wesley M. Oler						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 13, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wesley M. Oler M.D.						22e. ADDRESS 3301 N. Mexico Av NW Washington DC 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/14/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25. DATE REC'D. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE John Anderson Handell	

MEDICAL CERTIFICATION

17200351501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, report the medical examiner must be notified at once.

BP

Washington, D.C. 20540

June 15, 1966

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: [illegible]

Dear Sir:

[illegible]

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[illegible]

[illegible]

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00-06657

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8614841			
1. DECEASED NAME (TYPE OR PRINT) John D Fleetwood JR.				2a. DATE OF DEATH MONTH DAY YEAR 5 13 86			
1. SEX MALE				2b. HOUR 1:50 PM			
4. RACE WHITE				5. DATE OF BIRTH MONTH DAY YEAR 9 8 11			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas				6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS			
7b. CITIZEN OF WHAT COUNTRY? USA				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FED. GOVT. (RET.)				12b. KIND OF BUSINESS OR INDUSTRY F.H.L.B.			
13a. STATE MD				13b. STREET ADDRESS / ZIP CODE 8412 20th Ave 20783			
13c. CITY OR TOWN ADELPHI				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN D. FLEETWOOD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH WOODS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 577-60-4259			
17. INFORMANT ADDRESS OLLIE LEE FLEETWOOD, 8412 20th Ave. ADELPHI							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Post-traumatic Asse...</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> 19 <u>86</u> to <u>5/12</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jay Weiner				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner				22e. ADDRESS 4701 Rockville Rd Rockville, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Park Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood MD	
24. FUNERAL DIRECTOR NAME TAKOMA F.H. INC. 254 CANNON ST. N.W. WASH. D.C. 20015				25a. DATE REC'D. BY REGISTRAR MAY 15 1986			
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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00-07368

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 4 2

REG. NO.

1. DECEASED NAME (FIRST OR INITIAL) MIDDLE LAST Aileen May Floyd			2. DATE OF DEATH MONTH DAY YEAR 5 17 86			3. HOUR 10 50 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 28 02		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Oren E Owens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian B Candee		16. STREET ADDRESS / ZIP CODE 403 Ellsworth Drive 20910			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 496-26-6162		17. INFORMANT Daughter		ADDRESS 20910 Silver	
				Nancy Jo Floyd		213 Hillsboro Drive Spring, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **sepsis and dehydrated**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 17 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1106 Spring St. Silver Spring MD			
22a. I certify that (I) (this hospital) attended the deceased from 2 19 86 to 5 17 19 86 , that (I) (we) last saw the deceased alive on 5/17 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Deborah B Goldberg				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah B Goldberg				22e. ADDRESS 1106 Spring St. Silver Spring MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE James B. [Signature]	
500 University Blvd. West Silver Spring, Md.							

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-06085

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

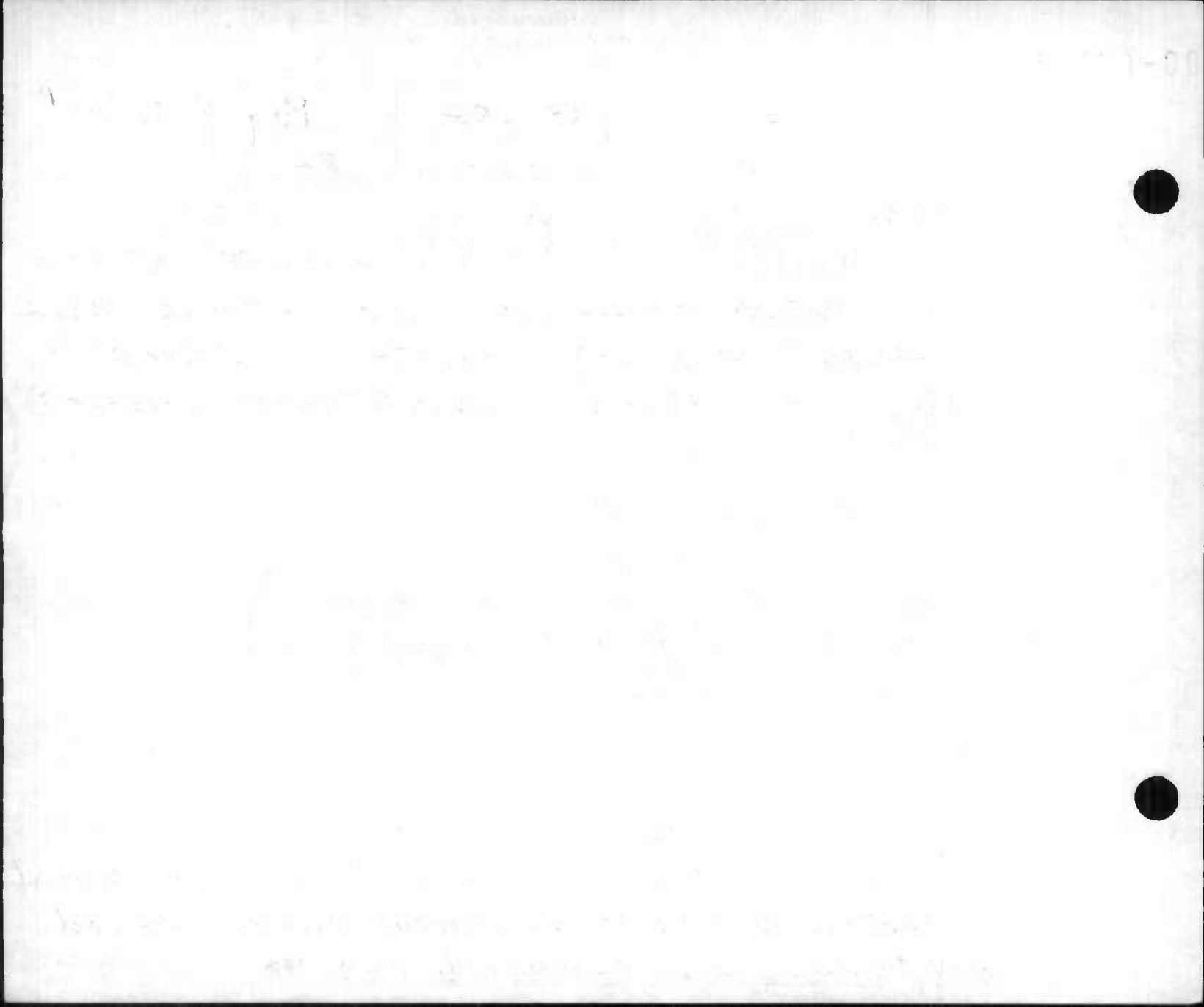
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 14843			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
DECEASED NAME FIRST MIDDLE LAST CHARLOTTE E. FORSBERG				MAY 4 86 640 P M			
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 - 20 - 04		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINN.		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Caringage Nursing Center 9101 Second Avenue Silver Sp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY AT HOME	
13a STATE Md.				13b COUNTY MONTGOMERY		13c CITY OR TOWN ROCKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ROSENBLAD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGUSTA BYLUND			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 471-54-8600		17 INFORMANT ADDRESS HELEN F. ROTHENBERG (SAME AS #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complicated hemorrhage</u> 24 hrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> 8-10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Ileostomy 27 Mar 86 (Intubation) obstructions</u>							
19a DATE OF OPERATION 27 Mar 86		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstruction</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>19 Apr 86</u> to <u>4 May 86</u> , that (I) (we) last saw the deceased alive on <u>4 May 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>W. W. Chambers</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4 May 86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W. W. Chambers		22e ADDRESS 50 WEST EDMUNSTON DR., ROCKVILLE, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE MAY 5, 1986		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGC., MD.	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. INC. SILVER SPRING, MD.				25a DATE REC'D. BY REGISTRAR MAY 9 1986			
				25b REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			

BP _____



00-06600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 14844			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Neely Foster				2b. HOUR 8:25 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 24, 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 95	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2913 Jennings Road 20895			
14. FATHER'S NAME FIRST MIDDLE LAST William Fraley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie C. Steele			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-74-0390		17. INFORMANT Robert A. Foster, Jr. Son Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several minutes</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>October 25, 1968</u> to <u>May 12, 1986</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bennet A. Porter, Jr. M.D.				DEGREE M.D.		22c. DATE SIGNED May 12, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bennet A. Porter, Jr. M.D.				22e. ADDRESS 9301 Colesville Rd, Silver Spring, Md. 20901			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR MAY 15 1986			
500 University Blvd., W. Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE [Signature]			

BP

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00-09204STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14845

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
David G. Fox		MALE		WHITE	
5 DATE OF BIRTH		6 AGE IN YEARS		7 IF UNDER 1 YR.	
JAN. 12, 1912		24		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH	
PENNSYLVANIA		XXX NEVER MARRIED		Montgomery MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION	
S. I. Sp.		Holy Cross Hosp.		ACCOUNTANT	
12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS		13b CITY OR TOWN	
FED. GOV'T.		20910		SILVER SPRING	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
MORRIS S. FOX		ANNA SANDLER		NO	
16b SOCIAL SECURITY NO.		17 INFORMANT		18 CAUSE OF DEATH	
579-16-8321		SARA FOX, 8602 LEONARD DRIVE, SILVER SPRING, MARYLAND		PART I DEATH WAS CAUSED BY:	
				IMMEDIATE CAUSE (a) Acute Myocardial Infarction	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) Chronic Myocardial Disease	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
				None	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY		21c HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION	
				CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY)	
ACTUAL SIGNATURE		MEDICAL EXAMINER		DATE SIGNED	
DR. JOHN S. ROGERS, M. D.		1919 SEMINARY ROAD		12/29/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		SILVER SPRING, MARYLAND	
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
BURIAL		6/1/1986		JUDEAN MEMORIAL GARDENS	
23d LOCATION		23e LOCATION		23f LOCATION	
OLNEY, MONTGOMERY, MARYLAND		OLNEY, MONTGOMERY, MARYLAND		OLNEY, MONTGOMERY, MARYLAND	
24 FUNERAL DIRECTOR		25 DATE RECEIVED BY REGISTRAR		25 REGISTRAR'S SIGNATURE	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		JUN 04 1986			
232 CARROLL STREET, N. W., WASHINGTON, D. C.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATION

12/1/77

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REF. NO. 4846

1. DECEASED NAME (TYPE OR PRINT)		FIRST Virginia		MIDDLE C.		LAST Freeman		REG. NO.		2a. DATE KNOWN OF DEATH		ESTI. MATED		MONTH 5		DAY 11		YEAR 1986		2b. HOUR	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 07 DAY 04 YEAR 1988		6. AGE (IN YEARS) (LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH 5		DAY 11		YEAR 1986		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10103 EAST BEXHILL DR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		20895	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10103 EAST BEXHILL DR		14. FATHER'S NAME FIRST Spencer MIDDLE -- LAST Cryer		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE -- LAST --		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-60-4273		17. INFORMANT Bob M. Freeman,		ADDRESS 9797 Reading Road Reading, Ohio 45215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MY CARDIAC INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) -- PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) --		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDIG		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30 P.M. 5 11 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET 10103 EAST BEXHILL DR CITY OR TOWN KENSINGTON COUNTY MONT STATE MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		22b. I certify that I took charge of the remains described above, held on		22c. I certify that I took charge of the remains described above, held on		22d. I certify that I took charge of the remains described above, held on		22e. I certify that I took charge of the remains described above, held on		22f. I certify that I took charge of the remains described above, held on		22g. I certify that I took charge of the remains described above, held on		22h. I certify that I took charge of the remains described above, held on		22i. I certify that I took charge of the remains described above, held on		22j. I certify that I took charge of the remains described above, held on		22k. I certify that I took charge of the remains described above, held on	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN Rockville, MD		23e. DATE REC'D. BY REGISTRAR MAY 16 1986		23f. REGISTRAR'S SIGNATURE John Davidson		23g. DATE REC'D. BY REGISTRAR MAY 16 1986		23h. REGISTRAR'S SIGNATURE John Davidson		23i. DATE REC'D. BY REGISTRAR MAY 16 1986		23j. REGISTRAR'S SIGNATURE John Davidson		23k. DATE REC'D. BY REGISTRAR MAY 16 1986	
24. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24a. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24b. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24c. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24d. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24e. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24f. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24g. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24h. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24i. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016		24j. FUNERAL DIRECTOR NAME 5130 Wisconsin Ave, NW, Washington, D.C. 20016	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 261 W. PLESSION STREET,
 BAIT MORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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00-06045

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 4 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		DATE		HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
LANA F FRITZ		5 3 1986		12 27 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		MONTH DAY YEAR	
				3 31 1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
MARYLAND		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
ROCKVILLE		Shady Grove Adventist Hospital		MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
HOUSEWIFE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		MONTGOMERY		POOLESVILLE	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13d. STREET ADDRESS / ZIP CODE	
JACOB T FISHER		LEILA MORNINGSTAR		19530 FISHER AVE 20837	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-05-1868		19530 FISHER AVE POOLESVILLE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a) Massive myocardial infarction		5/3/86	
		DUE TO, OR AS A CONSEQUENCE OF (b) Extensive cardiovascular DTS		years	
		DUE TO, OR AS A CONSEQUENCE OF (c)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/3/86, 19, to 19, that (I) (we) last saw the deceased alive on 5/3/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
		22c. DATE SIGNED		5/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DR. OSOTH LEKAGUL		7425 Arlington Rd Beltsville, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		5-5-86		MONOCACY	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
W.C. HILTON		22111 BEALLSVILLE Rd BARNESVILLE, Md-20838		MAY 07 1986	
				25b. REGISTRAR'S SIGNATURE	
				Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

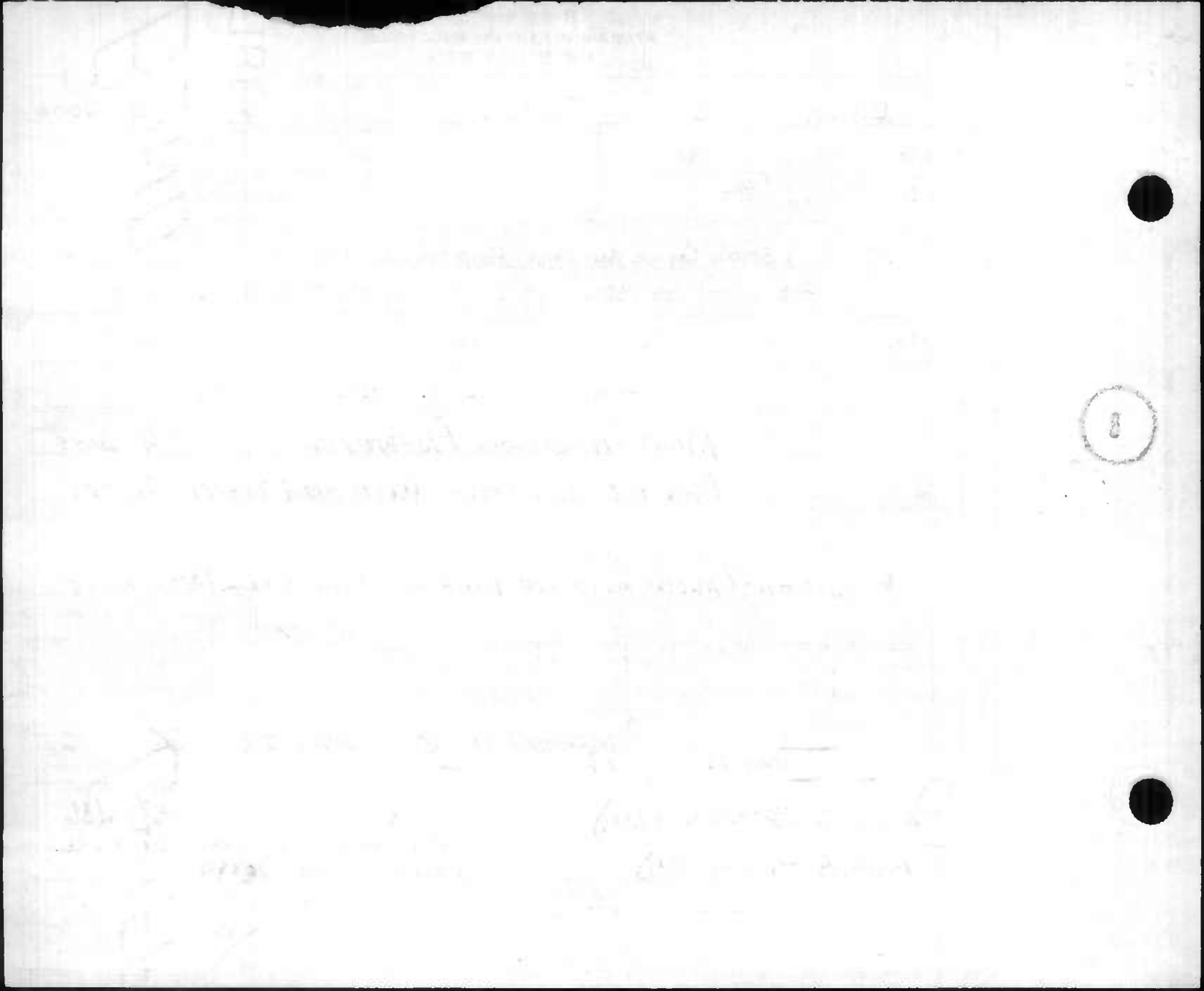
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eileen MIDDLE: S. LAST: Furlow			2b. DATE OF DEATH MONTH: 5 DAY: 23 YEAR: 86 TIME: 1200 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH: 9 DAY: 18 YEAR: 17	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Canada	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY private
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 525 Lincoln St. 20850
14. FATHER'S NAME FIRST: Stanley MIDDLE: Davis		15. MOTHER'S MAIDEN NAME FIRST: Anne MIDDLE: Greene LAST: Greene		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-14-4871	17. INFORMANT ADDRESS Lester W. Furlow same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RIGHT UPPER LOBE PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>20 YRS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>EPIDERMOID CARCINOMA OF LEFT LUNG WITH RIGHT LUNG METASTASES</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 16, 1985</u> to <u>MAY 23, 1986</u> , that (I) (we) last saw the deceased alive on <u>MAY 22, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>James C. Brown MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>5/23/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. BROWN MD</u>	22e. ADDRESS <u>14800 PHYSICIANS LANE, SUITE 232 ROCKVILLE, MD 20850</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-27-86	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md	
24. FUNERAL DIRECTOR Donard V. Borgwardt 4400 Powder Mill Rd. Beltsville Md 20705		25. DATE RECEIVED BY REGISTRAR MAY 28 1986		
		26. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION



0-05883

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

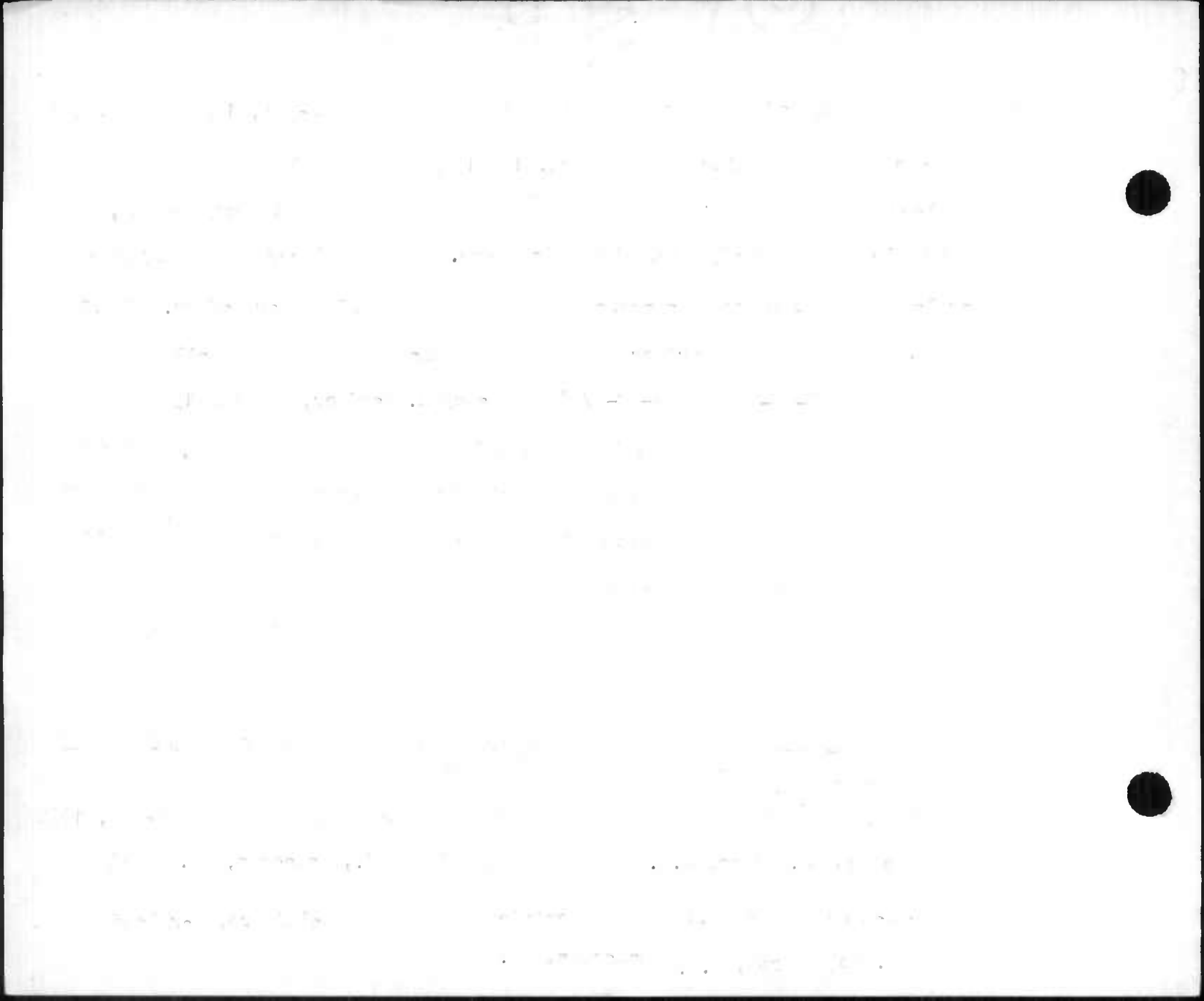
8 6 1 4 8 4 9

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Conrad Ivan GARDNER			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1986		2b. HOUR 8:55 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Mining	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Gardner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 057-09-0769	17. INFORMANT ADDRESS Nancy B. Gardner, Item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WEEK MANY YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a: <u>BRADY CARDIA SYNDROME WITH PACEMAKER.</u>					
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> 19 <u>86</u> to <u>5/5</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Kenneth J. Weiss MD</u>			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 5, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth J. Weiss, M.D.			22e. ADDRESS 26250 Ridge Rd., Damascus, Md. 20872		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE May 6, 1986	23c. NAME OF CEMETERY OR CREMATORY Westview	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR MAY 7 1986	25b. REGISTRAR'S SIGNATURE <u>Rendall</u>	

BP



00-07984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14850

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR											
JAMES			GARNER			5-26-86			19			M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Male		Caucasian		May 9, 1964		22 YRS.		MONTHS DAYS		HOURS MIN		5-26-86		1:40 P.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia				U.S.A.				WIDOWED NEVER MARRIED DIVORCED				Montgomery County											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring				Holy Cross Hospital				N/A				N/A											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Montgomery				Silver Spring				YES XX NO				12001 Cherry Hill Rd 20904							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
Harry								Nancy Ann Justice															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?								16b. SOCIAL SECURITY NO.								17. INFORMANT ADDRESS							
N/A								214-84-6561								Harry Garner Clinton, Maryland 20735							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Mental retardation with complications			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES NO XX	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
Actual Signature TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5-27-86					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		05/30/86		Ft. Lincoln Cemetery		Suitland Prince George's Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.				MAY 29 1986			
6633 Old Alexander Ferry Rd. Clinton, Md. 20735							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

DHMM - 17

(VR A15 ME)



00-07545

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

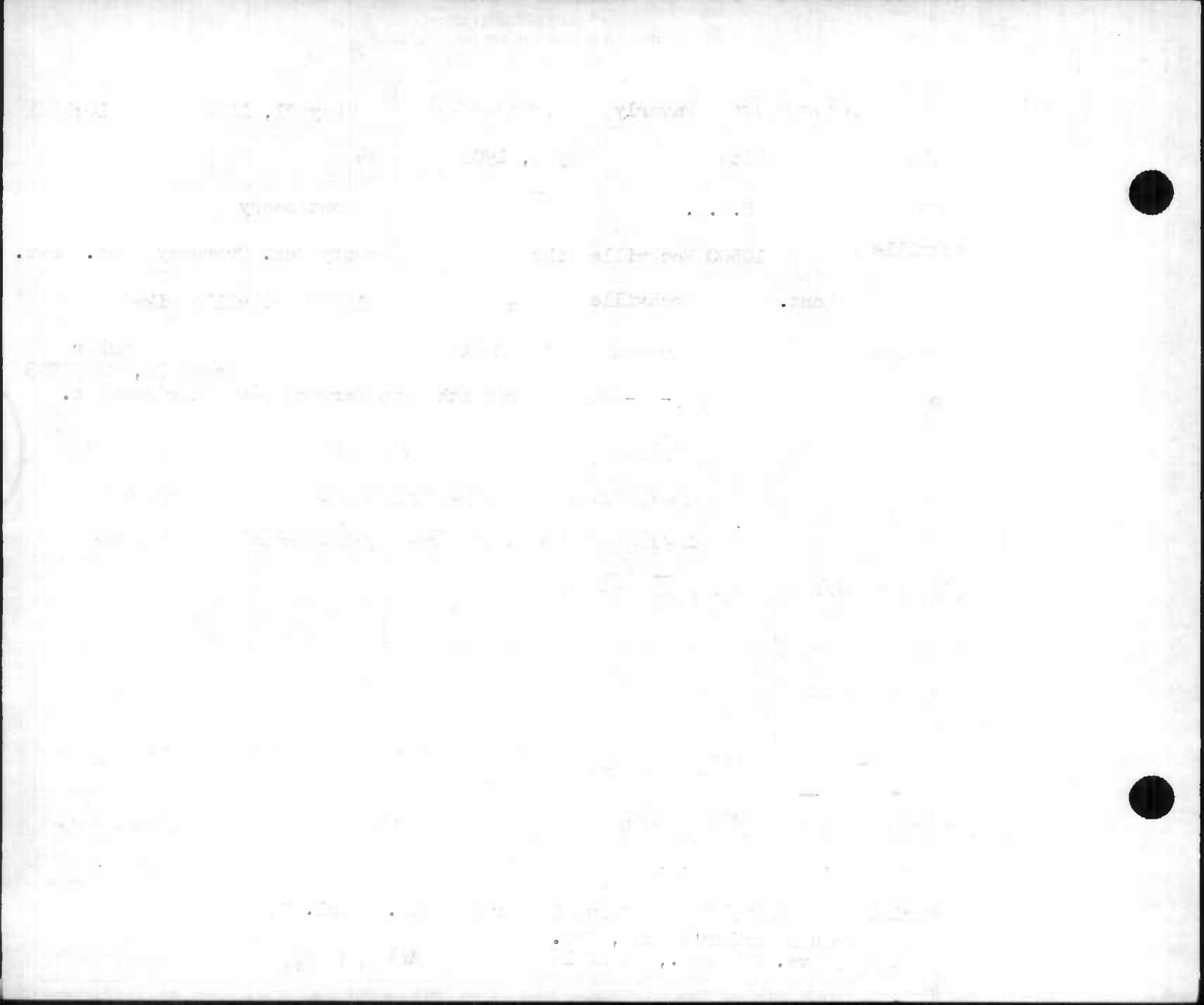
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8614851	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRIFFITH Waverly GARWOOD					2a. DATE OF DEATH MONTH DAY YEAR May 21, 1986			2b. HOUR 10:15^{AM}			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OH		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10500 Rockville Pike				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Con. Currency		12b. KIND OF BUSINESS OR INDUSTRY Fed. Govt.			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10500 Rockville Pike 20852			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Garwood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Packer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-58-4803		17. INFORMANT ADDRESS Griffith Lane Garwood 3402 Charleson St. Annandale, VA 22003							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) WIDESPREAD METASTASES 9 MO DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE PROSTATE 3 YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BONEY METASTASES & PATH. FRACTURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/20 19 86 to 5/21 19 86 that (I) (we) lost saw the deceased alive on 5/20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard P. Delaney</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/22/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.				22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/86		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Art. VA					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				24b. ADDRESS 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP



00-07518

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medicolegal examiner will be notified and a medicolegal certificate will be required.

BP

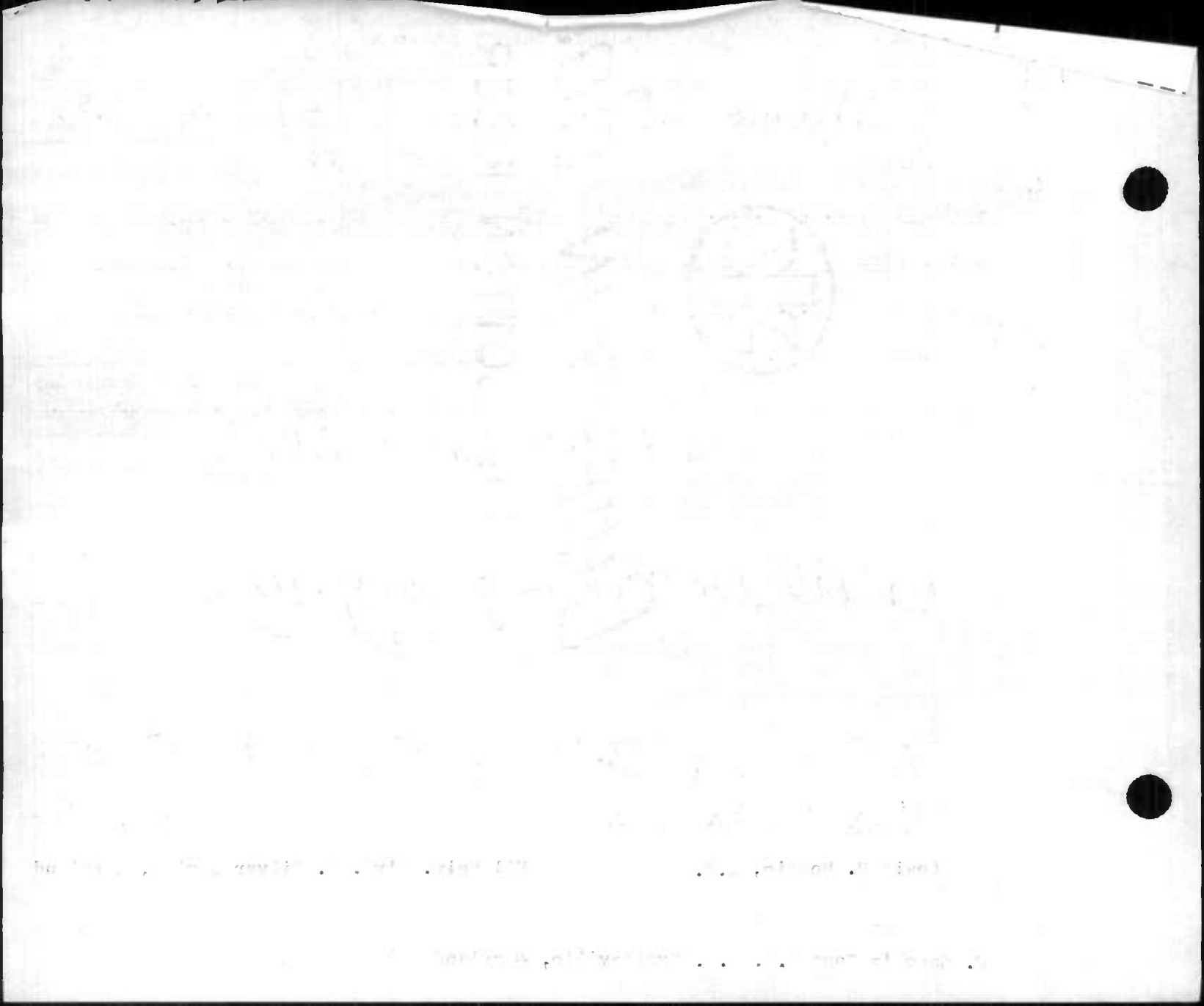
DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614852

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mamie O. Gasch			2a. DATE OF DEATH MONTH DAY YEAR 5/19/86		2b. HOUR 2⁵⁰ A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 15 05		
6. AGE (IN YEARS (LAST BIRTHDAY)) 80		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STATE Maryland				
13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3512 52nd Avenue 20781		14. FATHER'S NAME FIRST MIDDLE LAST Carl L. Lasanska				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta M. Firestein		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 217-72-4255		17. INFORMANT ADDRESS Joan Thomas (Daughter) Upper Marlboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: probable long term myocardial infarction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:57 P.M. 5/19/86		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b OR PART 2) myocardial infarction		
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21c. LOCATION (CITY OR TOWN) (COUNTY) (STATE) Brentwood P.G. Maryland		
22a. I certify that (1) this hospital attended the deceased from 5/18/86 to 5/19/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (did not) view the body after death.						
22b. SIGNATURE Lewis H. Dennis, M.D.		DEGREE M.D.		22c. DATE SIGNED 5/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 831 Univ. Blvd. E. Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		
23d. LOCATION (CITY OR TOWN) (COUNTY) (STATE) Brentwood P.G. Maryland		23e. DATE REC'D. BY REGISTRAR MAY 26 1986				
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE J. A. Davidson				



00-05774

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 5 3
REG. NO.

1. RELEASED NAME (TYPE OR PRINT) Rose		FIRST L.		MIDDLE Gerig		LAST		2a. DATE OF DEATH MONTH DAY YEAR May 4, 1986		2b. HOUR 8:00 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 05 91		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Maker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN OLNEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17904 LAFAYETTE DRIVE 20832			
14. FATHER'S NAME FIRST MIDDLE LAST GERSON - SCHERZINGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE - BEYERLEIN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 303-38-6291		17. INFORMANT ADDRESS ELIZABETH ANGEL SAME AS # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) VALVULAR HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PREVIOUS ISCHEMIC HEART DISEASE / CHRONIC ASPIRATION PNEUMONIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 5/3 , 19 86 , to 5/4 , 19 86 , that (1) (we) lost saw the deceased alive on 5/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death											
22b. SIGNATURE Francis H. Barber		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis H. Barber		22e. ADDRESS 5540 TEN OAKS RD. CLARKSVILLE, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 8, 1986		23c. NAME OF CEMETERY OR CREMATORY LINDEN WOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FT. WAYNE ALLEN INDIANA					
24. FUNERAL DIRECTOR FRANCIS H. BARBER		LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE June Barber					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

17723-00

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00-06285

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove without delay to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8614854 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN LEVY GOLD					2a. DATE OF DEATH MONTH DAY YEAR 5 3 86				
3. SEX Female					4. RACE White				
5. DATE OF BIRTH MONTH DAY YEAR August 3, 1903					6. AGE (IN YEARS LAST BIRTHDAY) 82				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.					7b. CITIZEN OF WHAT COUNTRY? U. S. A.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.				
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary					12b. KIND OF BUSINESS OR INDUSTRY Columbia Picture Corp.				
13a. STATE Maryland					13b. COUNTY Montgomery				
13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS / ZIP CODE 6121 Montrose Road 20852									
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Levy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Levy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-8049				
17. INFORMANT Marilyn D. Cohen					ADDRESS 911 LaGrande Road, Silver Spring, Md. 20903				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>abdominal distention</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 hrs 24 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					21d. LOCATION STREET CITY OR TOWN COUNTY STATE				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> , 19 <u>86</u> , to <u>May 3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE <u>Mark Rosen MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED 5/3/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen					22e. ADDRESS 3941 Ferrara Drive, Silver Spring MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 5/5/ 1986				
23c. NAME OF CEMETERY OR CREMATORY District of Columbia					23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.				
23e. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					23f. DATE REC'D. BY REGISTRAR MAY 08 1986				
23g. REGISTRAR'S SIGNATURE John Davidson-Randall									

10-13-50

WIKI TITLED

433-10000 6008



00-06084

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth		FIRST RUTH MIDDLE		LAST GOLDBERG		2a. DATE OF DEATH MONTH DAY YEAR 5 5 86		2b. HOUR 1400	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 14 13		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SWITCH-BOARD OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY HOTEL			
13a. STATE NEW YORK		13b. COUNTY SULLIVAN		13c. CITY OR TOWN MONTICELLO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 24 HILLSIDE GARDENS APTS. 11995	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY KATZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE SCHWARTZ		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 116-28-0996		17. INFORMANT ADDRESS STUART GOLDBERG, SON, 41 WINFRIED DAVIS DR.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF: (b) Adult Respiratory Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF: (c) POSSIBLE Viral Pneumonia									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 23 , 19 86 , to May 5 , 19 86 , that (I) (we) last saw the deceased alive on May 5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Louis J Larca		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS J LARCA		22e. ADDRESS 7600 Carroll Ave TAKOMA PARK, MD 20915							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/7/86		23c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WOODBIDGE, MIDDLE SEX, NJ			
24. FUNERAL DIRECTOR NAME I. J. MORRIS, INC.		ADDRESS 21 EAST DEER PARK RD., DIX HILLS, NY 11746		25a. DATE REC'D. BY REGISTRAR MAY 9 1986		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



00-06472

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 8 5 6

1. DECEASED NAME (TYPE OR PRINT) CHARLES GOLDSTEIN			2a. DATE OF DEATH MONTH DAY YEAR 5/9/86		2b. HOUR 6:10 M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10/19/95		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (Rep.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Garment Manufact		
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Louis Goldstein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I	17. INFORMANT ADDRESS Bethesda, Md. 20817 Elliot Cines; Son; 8704 Bradmoor Drive;			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YEARS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC HEART DISEASE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 2/25 19 85 to 5/9 19 86 , that (b) (we) last saw the deceased alive on 5/9 19 86 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above and (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven Lipson MD		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN LIPSON		22e. ADDRESS 6171 MONTROSE RD, ROCKVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/12/86	23c. NAME OF CEMETERY OR CREMATORY Acacia Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Ozone Park, New York		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE REC'D. BY REGISTRAR MAY 12 1986			
1170 Rockville Pike; Rockville, Md. 20852		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

00-06656

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please use carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 8 5 7

1. DECEASED NAME (TYPE OR PRINT) Tia Jenina Golson			2a. DATE OF DEATH MONTH DAY YEAR May 9 1986		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 9 1986		6. AGE (IN YEARS LAST BIRTHDAY) New born YRS. MONTHS DAYS HOURS MIN. 1 41	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? N/A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE DC		13b. COUNTY DC	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Love Golson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennifer Patricia Rivers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): No gross abnormalities noted.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Allen Brimmer M.D.		DEGREE M.D.		22c. DATE SIGNED 5-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen Brimmer MD.		22e. ADDRESS 10500 Summit Ave Kens, Md 20895			
23a. BURIAL, CREMATION, REMOVAL (DIRECTOR) Hospital		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 15 1986	
				25b. REGISTRAR'S SIGNATURE John H. ...	



The following information is for your information only.
It is not to be used for any other purpose.

00-07579

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mercy Anna Goodloe			2a. DATE OF DEATH MONTH DAY YEAR 5 6 86		2b. HOUR 8:49 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 6 86		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 0 0 IF UNDER 24 HRS HOURS MIN. 2 37	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY DC 13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 99999 4201 New Hampshire Ave NW	
14. FATHER'S NAME FIRST MIDDLE LAST John Paul Goodloe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Deleta Arnold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Candice's Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pre-Viable Premature Birth DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours, 37 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-6 , 19 86 , to 5-6 , 19 86 , that (I) (we) last saw the deceased alive on 5-6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence F. Cohen MD		DEGREE		22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence F. Cohen, MD		22e. ADDRESS 7600 Carroll Ave, Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL (IF NOT, GIVE STREET ADDRESS) Hospital		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D. BY REGISTRAR MAY 26 1986			

BP
DHMH-16 (FORM 2/80)
(VRA (5, 4))

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00-08077

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie L. Goodwin			2a. DATE OF DEATH MONTH DAY YEAR 5-23-86 HOUR 1:40 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1-24-1892	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS MONTHS DAYS HOURS MIN.	7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 918 Snure Rd. Silver Spring Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland			13b. COUNTY Montgomery		
13c. CITY OR TOWN Silver Spr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 918 Snure Rd 20902			14. FATHER'S NAME FIRST MIDDLE LAST Buck M. Roland		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Sellner			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO 578-44-5678			17. INFORMANT ADDRESS Jean R. Wells 78 Sweetbriar Br. Longwood Fl.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Stroke					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 5/23 1986	
22a. I certify that (I) (this hospital) attended the deceased from 5/23 1986 to 5/23 1986 , that (I) (we) last saw the deceased alive on 5/23 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (not) view the body after death.					
22b. SIGNATURE T. Chanchein				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. Chanchein				22e. ADDRESS 8824 Cunningham Dr. Berwyn Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-27-1986		23c. NAME OF CEMETERY OR CREMATORY Sellner Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Friendley P.G. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.			
25a. DATE REC'D BY REGISTRAR MAY 29 1986				25b. REGISTRAR'S SIGNATURE Jane Harrison-Randall	

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John J. Wells

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Page 10

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00-07234

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 3 6 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Susan Lee Gordon		May 16, 1986		10:00 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	34	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Virginia		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		NIH, THE CLINICAL CENTER		Editor	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Kensington	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		3505 Lawrence Ave. 20895	
Richard N. Gordon		Margaret E. Hyland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		223-76-1980	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		CARDIO PULMONARY ARREST		ACUTE	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) SEPSIS (SPLENIC, KIDNEY, LIVER)		3 WEEKS	
		(c) ACUTE LYMPHOBLASTIC LEUKEMIA		9 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from December 13, 1977 to May 16, 1986 that (we) lost saw the deceased alive on May 16, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Francisco J. Barriga		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		5/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Francisco J. Barriga		National Institutes of Health Clinical Center, Bethesda, Md. 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY STATE	
Cremation	5/17/86	Chambers Crematory	Riverdale	P.G. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co. Inc.		5801 Cleveland Ave. Riverdale Md. 20737		MAY 21 1986 John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove remaining carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-06192

Film G-16 item 14

1- STATE
REGISTRAR 5/5/86 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14861

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Albert Graham			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/6 1986		2b. HOUR M 6:40 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1924	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 62	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 62	IF UNDER 24 HRS. 62
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3705 Fairly Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Railroad	
12b. KIND OF BUSINESS Washington Terminal Co.					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3705 Fairly Street 20906			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Graham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Pinkerton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II Korea 578-26-3016		17. INFORMANT ADDRESS Leah M. Graham same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/86		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery Cheltenham, Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAY 12 1986			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		24a. DATE REC'D. BY REGISTRAR MAY 12 1986		24b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
1331 Rockville Pike, Rockville, Maryland 20852					

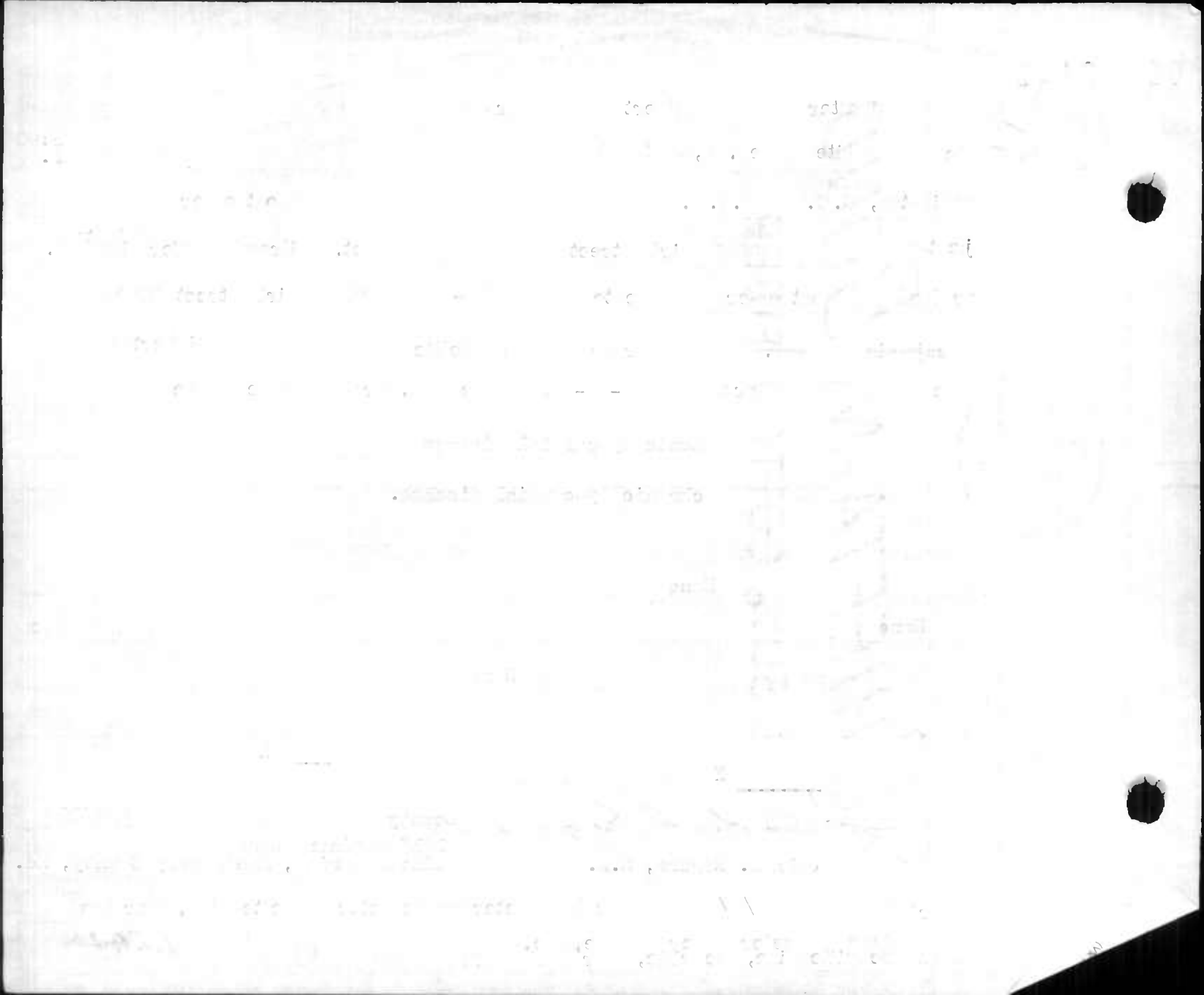
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(15 ME (5))



00-066591

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14862

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIA CANALS GROESBECK			2a. DATE OF DEATH MONTH DAY YEAR MAY 11 1986		2b. HOUR 6:25 P^M	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 23 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE VIRGINIA		13b. COUNTY FAIRFAX	13c. CITY OR TOWN MCLEAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1142 DALEVIEW DRIVE 22102	
14. FATHER'S NAME FIRST MIDDLE LAST MIGUEL CANALS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUANA CAMELLAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 579-62-8853		17. INFORMANT ADDRESS DOROTHY G. MCCLINTIC, 1142 DALEVIEW DRIVE,			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) SENILE DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **APRIL 29**, 19 **86**, to **MAY 11**, 19 **86**, that (I) (we) last saw the deceased alive on **MAY 11**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>James M. Guinee MD</i>	DEGREE	22c. DATE SIGNED 12 May 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. GUINEE, LT. MC, USNR	22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 5/13/86	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA
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24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009	25a. DATE REC'D. BY REGISTRAR MAY 15 1986	25b. REGISTRAR'S SIGNATURE <i>James M. Guinee</i>
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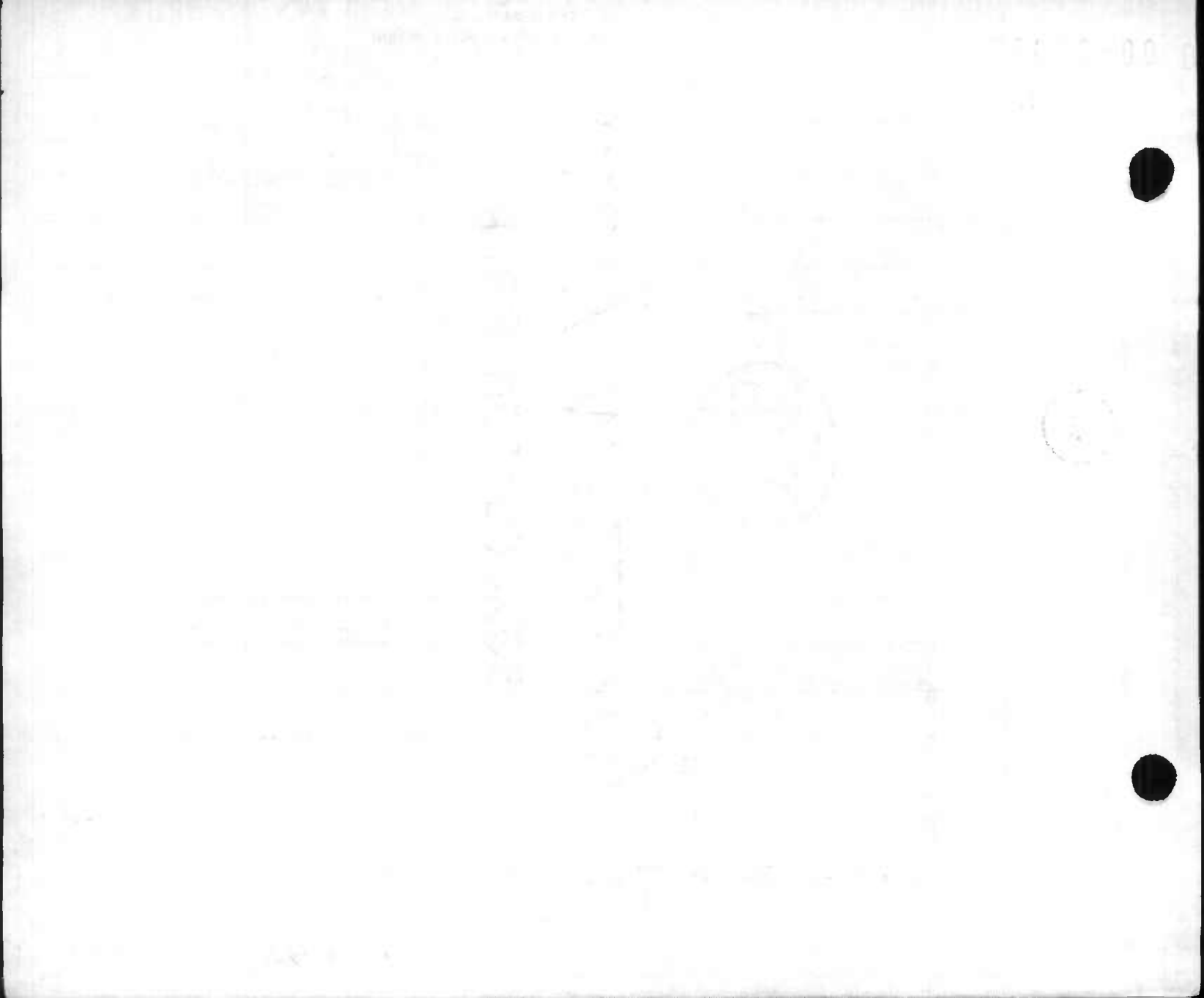
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's stamp. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP



00-05988

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLIFFORD F. HALE			2a. DATE OF DEATH MONTH DAY YEAR 5 6 86		2b. HOUR 9:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 7 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaner		12b. KIND OF BUSINESS OR INDUSTRY Sterling Laundry
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5600 Gallatin St 20781	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Otho Hale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Susan Fogle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-09-4699		17. INFORMANT ADDRESS Effie R. Hale (Wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Metastatic Carcinoma from lung					
19a. DATE OF OPERATION 5-4	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perineal infection		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 4 , 19 86 , to May 6 , 19 86 , that (I) (we) last saw the deceased alive on May 5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fredric Cantor		DEGREE MD		22c. DATE SIGNED 5-7	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fredric Cantor		22e. ADDRESS 7500 Hanover Phwy Greenbelt			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/10/86	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL HOME NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR MAY 8 1986		25b. REGISTRAR'S SIGNATURE John Swanson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completed by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

100-100000



00-06807

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY L. HALE			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1986		2b. HOUR 10:00 p.
3. SEX Femlae	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Retirement & Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12817 Chrisfield Rd. 20906	
14. FATHER'S NAME FIRST MIDDLE LAST John F. Hancock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna H. Horstmann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-20-1962	17. INFORMANT ADDRESS Jeffery Hale 2783 Grovemore Lane Vienna, Va. 22180			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Endometrium DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 14, 1983 to 5/8, 1986 , that (I) (we) last saw the deceased alive on 5/3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard S. Goldstein		DEGREE MD		22c. DATE SIGNED 5/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard S. Goldstein		22e. ADDRESS 4701 Randolph Rd, Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/13/86	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Wheeler Funeral Home, Inc.		25a. DATE RECD. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS 1331 Rockville Pike, Rockville, Md. 20852					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/B4
(VRA 15, 4)1- FOR
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola B. Hamilton			2a. DATE OF DEATH MONTH DAY YEAR May 11, 1986		2b. HOUR 10:PM AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 30 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? Permanent resident	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Burtonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14309 Perrywood Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Child Care	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Burtonsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 14309 Perrywood Dr. 20866	
14. FATHER'S NAME FIRST MIDDLE LAST (unobtainable) Biganski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unobtainable)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 034-16-4325		17. INFORMANT (Step-daughter) ADDRESS Betty Jane Turner (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>May 9</u> , 19 <u>86</u> , to <u>May 11</u> , 19 <u>86</u> , that (2) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edward P. Taubman</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Taubman, MD		22e. ADDRESS 18111 Prince Philip Dr. Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE May 12, 1986	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1986	
25b. REGISTRAR'S SIGNATURE <u>Jane Davidson</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 40 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 (1) is an injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 14866	
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN OLIVER HARDESTY				2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1986				2b. HOUR 11:50 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 20, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10401 GROSVENOR PL. #1122 20852			
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT HARDESTY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MARIA PERRY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-44-3768		17. INFORMANT ADDRESS EILEEN HARDESTY, WIFE, SAME AS ITEM #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia - Fibrillation										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE										UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) LABILE HYPERTENSION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from December 1979 to MAY 1986 , that (I) (we) last saw the deceased alive on MAY 20 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas Havel				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/35/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HAVELL, M.D.				22e. ADDRESS 4201 CATHEDRAL AVE., N.W., WASHINGTON, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/30/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA					
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009						25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodden			

TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
IN SENATE CHAMBERS
WASHINGTON, D. C.
JANUARY 1, 1900
BY
J. H. HARRIS
CLERK OF THE HOUSE

00-06893

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 21a, any injury, or other traumatic event, the medical examiner must be notified once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14867
REG. NO.FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROSE Abramovitz HARRIS		2a. DATE OF DEATH MONTH DAY YEAR 5-11-86		2b. HOUR 10 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 1 11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsburg, Penn	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1733 Crestview Dr. Rockville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY Montg.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Zachary Abramovitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Epstein.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 191-09-2441		17. INFORMANT ADDRESS Marjorie Weiner (same as #11)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Stem Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>8 hrs</u> <u>6 mos</u>
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, BARN, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> 19 <u>85</u> to <u>May 12</u> 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>March 27</u> 19 <u>86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not see the body after death.			
22b. SIGNATURE <u>Leonard A. Wisneski MD</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/12/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonard A. Wisneski MD		22e. ADDRESS 6410 Rockledge Dr. #308 Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE May 13, 1986	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Pk.	23d. LOCATION Falls Church, Fairfax Co., Va.
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MAY 14 1986

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2000-01-01
- 1 -

00-07053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard Harriston			2a. DATE OF DEATH MONTH DAY YEAR 5 17 86			2b. HOUR 9:30 P.M.				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR February 9, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington,		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT MD.				
10. CITY OR TOWN OF DEATH Takoma		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Seventh Day Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Gov't		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. STATE MD.			13b. COUNTY P.G.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2726 20746	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Harriston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natilie Douglas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 578-64-4879			17. INFORMANT ADDRESS Julia Harriston Wife 5068 Silver Hill Ct.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/16 , 19 86 , to 5/17 , 19 86 , that (I) (we) lost saw the deceased alive on 5/17/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE EDWIN KIRK HUNG						DEGREE MD		22c. DATE SIGNED 5/17/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 8300 Corporate DR LANDBOVER MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 22 May 86		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Frazier's Funeral Home 389 Rhode Island Avenue,						25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson		

BP

00-07539

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Arnold HAWKINS			2a. DATE OF DEATH MONTH DAY YEAR May 21, 1986		2b. HOUR 7:43P_M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR Feb. 6 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? American	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland			13b. COUNTY Montg.	13c. CITY OR TOWN Clarksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Franklin Hawkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Estelle Lyles		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-36-8161		17. INFORMANT ADDRESS Renee Coleman Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 10 years DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of prostate 6 years - DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 12/16 19 64 to 5/21 19 86 , that (I) lost saw the deceased alive on 5/14 19 86 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
23a. SIGNATURE James P. Kerr, M.D.		DEGREE		22c. DATE SIGNED May 22, 1986	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D.		22e. ADDRESS 26618 Ridge Rd., Damascus, Md. 20872			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/26/86	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Purdam Montg. Md.	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.,		ADDRESS Damascus, Md.		25. DATE REC'D. BY REGISTRAR MAY 26 1986	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

0-07349

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 7 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Vivie Hol Hayter</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 21, 1986</i>		2b. HOUR <i>10¹⁵ M</i>		
3 SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 10, 1891</i>		6. AGE (IN YEARS, LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <i>95</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i>	
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4103 Warner Street</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>4103 Warner Street 20895</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel H. Harrison</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Coates</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No N/A</i>	
16b. SOCIAL SECURITY NO. <i>478-44-0188</i>		17. INFORMANT (Son) <i>Lyle B.F. Hayter</i>		ADDRESS <i>4103 Warner St Kensington, Maryland</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>Arteriosclerosis - generalized</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> , 19 <i>64</i> , to <i>present</i> , 19 <i>86</i> , that (I) (we) lost <i>May 9</i> , 19 <i>86</i> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John B. Umhoe MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/21/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John B. Umhoe MD</i>		22e. ADDRESS <i>8805 Conn. Ave., Chevy Chase, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1986 May 27,</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anita Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Anita Iowa</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1986</i>		25b. REGISTRAR'S SIGNATURE	
PA. 7557 Wisconsin Avenue, Bethesda, MD							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06339

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 7 1

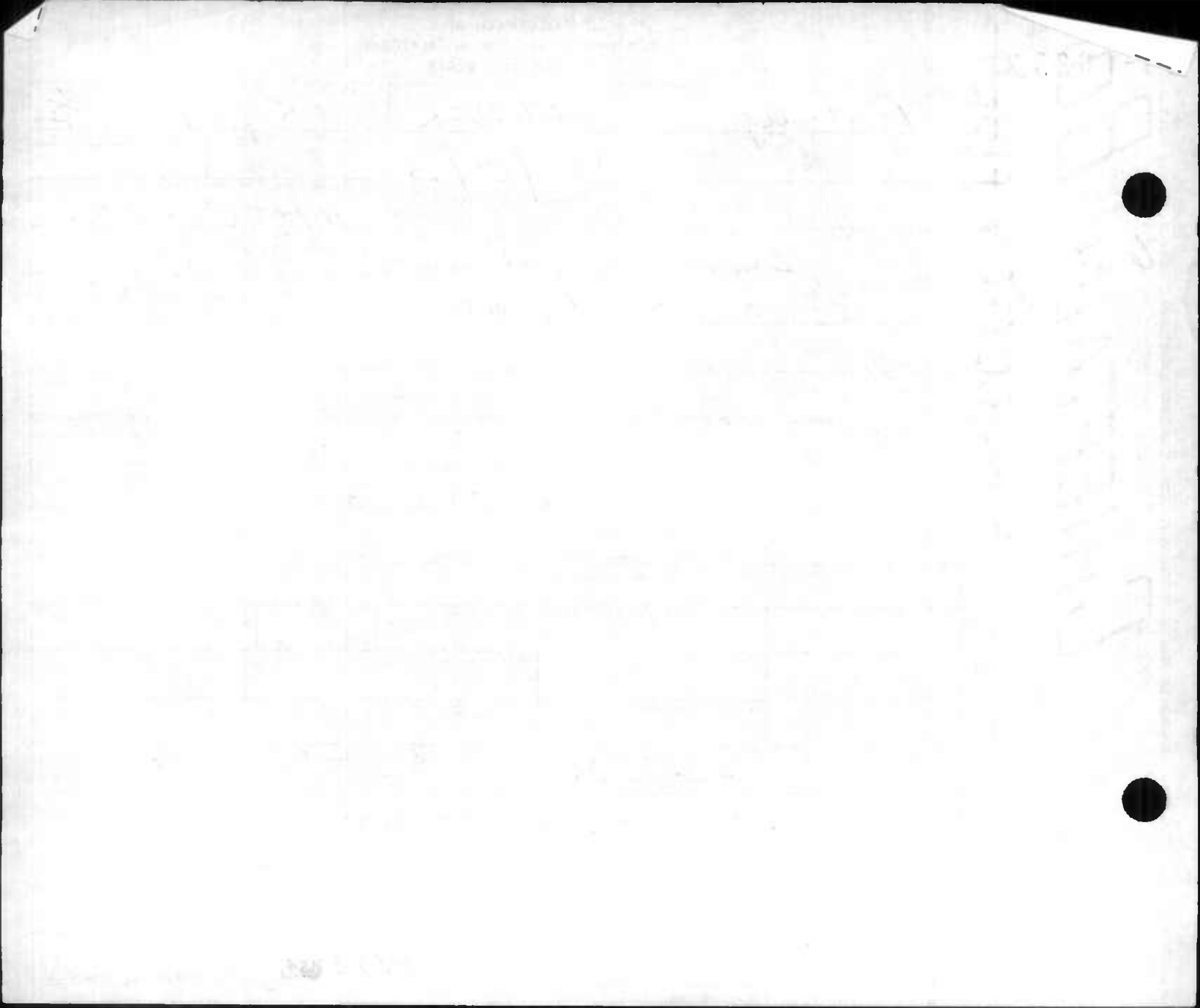
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETSEY EVANS HEACOCK		2a. DATE OF DEATH MONTH DAY YEAR 05/09/86		2b. HOUR 1:45	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09/07/15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 70	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing/Retirement		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD.	
13a. STATE MD		13b. COUNTY WASHINGTON, D.C.		13c. CITY OR TOWN WASHINGTON, D.C.	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER EVANS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAM CAYWOOD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-10-2095		17. INFORMANT DAVID HEACOCK, SON, SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 88 to 5 19 86 , that (I) (we) last saw the deceased alive on 4-14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Christopher Unger M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER UNGER, M.D.				22e. ADDRESS 8218 WISCONSON AVE., BETHESDA, MD. 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/9/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA		25a. DATE REC'D. BY REGISTRAR MAY 13 1986			
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009				25b. REGISTRAR'S SIGNATURE Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-07781

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 4 8 7 2
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3a. MONTH DAY YEAR		3b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE ESTIMATED		3b. MONTH DAY YEAR		3b. HOUR	
Ernest Allen Hebron		5 18 86		5 18 86		10 00	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Male	Black	1 MONTH 22 DAY 40 YRS.	46 YRS.	MONTHS DAYS HOURS MIN.	MONTHS DAYS HOURS MIN.	5 18 86	10 00
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.	U.S.A.	WIDOWED NEVER MARRIED DIVORCED		Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY			
Poolesville	14755 Sugarland Rd.	Laborer					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Montg.		Poolesville		YES NO	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
Lawrence A. Hebron		Ada E. Johnson		215-38-5911		Gwen Reese	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		215-38-5911		Gwen Reese		11 School Dr. # T2 Gaithersburg, Md. 20878	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)							
Cardiac arrest							
DUE TO, OR AS A CONSEQUENCE OF							
Coronary arteriosclerosis							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
alcohol addiction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION			
NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from:							
Natural causes Accident Suicide Homicide Undetermined manner							
Autopsy Inspection Inquiry and in my opinion							
Actual Signature							
John Tauber							
TITLE (SPECIFY)							
Deputy							
M.D. MEDICAL EXAMINER							
DATE SIGNED							
5-18-86							
EXAMINER'S NAME							
John Tauber							
ADDRESS							
8218 Wisconsin Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		5-23-86		St. Paul Cem.		Sugarland, Montg. MD	
24. FUNERAL DIRECTOR		24b. N. Washington St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George R. Snowden		Rockville, MD 20850		MAY 26 1986		Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

[Faint, illegible text covering the page, likely bleed-through from the reverse side.]

00-06219

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14873

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLORIA Agnes Heister		2b. DATE OF DEATH MONTH DAY YEAR MAY 3 1986		2c. HOUR 2:15P	
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 8 28		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Braintree, Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7516 Planter Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Clerk		12b. KIND OF BUSINESS OR INDUSTRY C&P Tele.Co.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Sloan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Ferguson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 016-22-2271		17. INFORMANT ADDRESS Robert Wm. Heister same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCD. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. 3 mos.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Multiple small strokes, post. cardiac arrest.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mar. 7, 19 86 , to May 3, 19 86 , that (I) (we) last saw the deceased alive on Apr. 20, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Jules R. Ladisch MD by Frederick Mooman, MD.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-5-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick Mooman, M.D.		22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, MD. 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/5/86		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.	
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.		ADDRESS 7601 SANDY SPRING RD. LAUREL, MD. 20707		25a. DATE REC'D. BY REGISTRAR MAY 12 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

1. The first of these is the fact that the

the second is the fact that the

the third is the fact that the

the fourth is the fact that the

the fifth is the fact that the

the sixth is the fact that the

the seventh is the fact that the

the eighth is the fact that the

the ninth is the fact that the

the tenth is the fact that the

the eleventh is the fact that the

the twelfth is the fact that the

the thirteenth is the fact that the

the fourteenth is the fact that the

the fifteenth is the fact that the

the sixteenth is the fact that the

the seventeenth is the fact that the

the eighteenth is the fact that the

00-00098

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 1 4 8 7 4	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCINE C. Haverly					2a DATE OF DEATH MONTH DAY YEAR 5 22 86			2b HOUR 7 18 A.M.			
3 SEX Female		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 5 12 12		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Food Industry			
13a STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George A Westover					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Belle Bryant						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 009-10-2922		17. INFORMANT Son ADDRESS Ernest Hanlon 10701 Georgia Avenue 20902						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Heart Disease											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 2 May 19 86 to 22 May 19 86, that (1) (we) last saw the deceased alive on 2 May 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 22 May 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leiberman					22e. ADDRESS 1116 N.H. Ave. St. 20905						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland				
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR JUN 2 1986						
25b. REGISTRAR'S SIGNATURE [Signature]											

2006

WITNESSES
D. J. [unclear]

FF. [unclear]

X

NOTARY PUBLIC FOR THE STATE OF TEXAS

My commission expires on _____

10

Notary Public

[unclear]

8

11

[unclear]

12

[unclear]

13

[unclear]

14

[unclear]

15

[unclear]

16

[unclear]

00-07365

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 8 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lillian W Heyer			2a. DATE OF DEATH MONTH DAY YEAR May 15, 1986		2b. HOUR 7:45 p.m.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 30 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Health Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Wilhelm		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Weigel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 220-44-0021		17. INFORMANT Kathryn H. Sperry Daughter Same as 13				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS, A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS, A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral Vascular Accident.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 1985 to May 1986, that (I) (we) lost saw the deceased alive on May 15 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. T. Benack MD				DEGREE MD		22c. DATE SIGNED 5/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. Benack MD				22e. ADDRESS 4115 Calie Dr. Wheaton, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 19, 1986		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

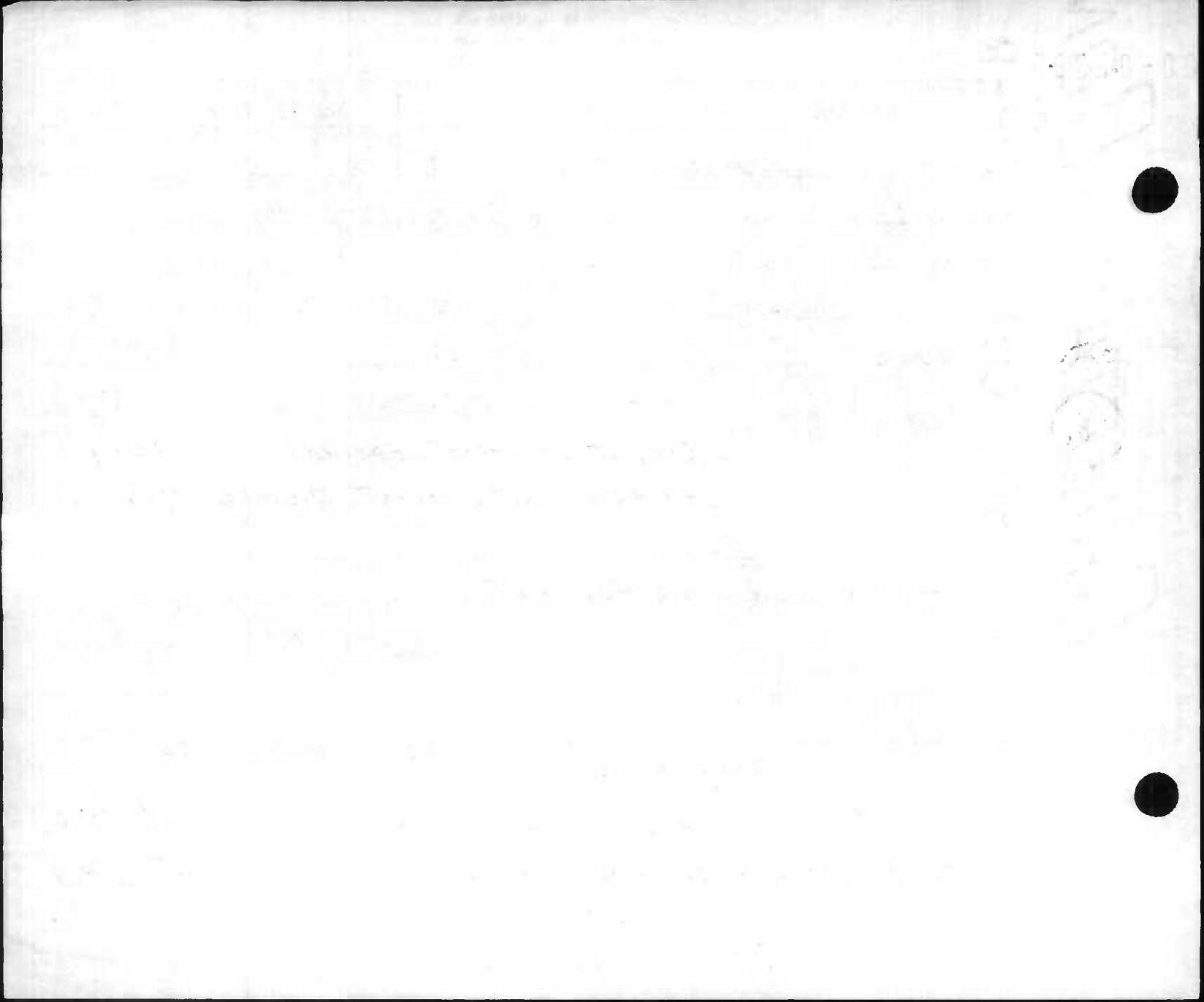
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's permit, page 2, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



3
00-08072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614876
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Ella M. Hildebrand		May 22, 1986		12:15pm	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 9, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89	7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10200 Clearbrook Place 20895
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Entenman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT (Daughter) ADDRESS Dorothy H. VonDrehle, Place, Kensington 10200 Clearbrook			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19____, to <u>May 22</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN MEDICAL STAFF DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 22, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank C. Blackburn, M.D.		22e. ADDRESS 5401 Western Avenue, N.W. Washington, D.C. 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 24, 1986	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Funeral Homes	
7557 Wisconsin Ave. Bethesda, MD 20814 PA		25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE	

BP

51010-0



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614877

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Carrie L. Hill</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 21, 1986</i>		2b. HOUR <i>9:45pm</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 18 1990</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Sil. Spr. Md.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Colonial Villa Nsg. Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>1006 Helena Drive 20901</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joe Sutherland</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Judith Edwards</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>235-05-4559-D</i>		17. INFORMANT <i>Daughter Northfork W., Virginia</i> <i>Mrs. Frances Hanna</i> <i>24868</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Small Bow Obstruction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Today</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>May 10, 1986</i> to <i>May 21, 1986</i> , that (2) we lost sight of the deceased alive on <i>May 10, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>22 May 86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Leibonik</i>		22e. ADDRESS <i>1124 N. H. Dr. N.E. 20901</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 25, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bluewill Mercer West Virginia</i>
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i> <i>500 University Blvd. Wst. Silver Spring, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 28 1986</i>		
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14878
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Robert H. Hill, Sr.			2a DATE OF DEATH MONTH DAY YEAR MAY 7, 1986			2b HOUR 3:15 PM			
3 SEX MALE		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR October 29, 1924		6 AGE (IN YEARS, LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CIA		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4700 Tallahassee Avenue 20853					
14 FATHER'S NAME FIRST MIDDLE LAST Samuel H. Hill			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bounds						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b SOCIAL SECURITY NO. 229-16-2831		17 INFORMANT ADDRESS Jane B. Hill Wife Same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular tachycardia - fibrillation DUE TO, OR AS A CONSEQUENCE OF: (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (c) myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 5/7 1986 to 5/7 1986 , that (I) (we) last saw the deceased alive on 5/7 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) saw the body after death.									
22b SIGNATURE B.N. ROSENBAUM				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/7/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSENBAUM				22e ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD 20891					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE May 8, 1986		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d LOCATION CITY OR TOWN COUNTY STATE Virginia			
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a DATE REG'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE MAY 12 1986					
500 University Blvd., W. Silver Spring, Md.									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.)

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FOR
1- STATE 7/1/86 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 8 7 9

1. DECEASED NAME (TYPE OR PRINT) Thelma C. Hines			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5/20 1986			2b. HOUR P. M. 2:45 P. M.			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Apr 10, 1921	6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 5/20 1986			2d. HOUR P. M. 2:45 P. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11235 Oakleaf Drive, #1102			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant Assist.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-26-5072			17. INFORMANT ADDRESS Arlana Hines, 112 Preston La. Pomefret, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, Md.			DATE SIGNED 5/21/86
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME McGuire Funeral Serv.			ADDRESS 7400 Georgia Ave. N.W.		25a. DATE REC'D. BY REGISTRAR JUN 02 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodale</i>		

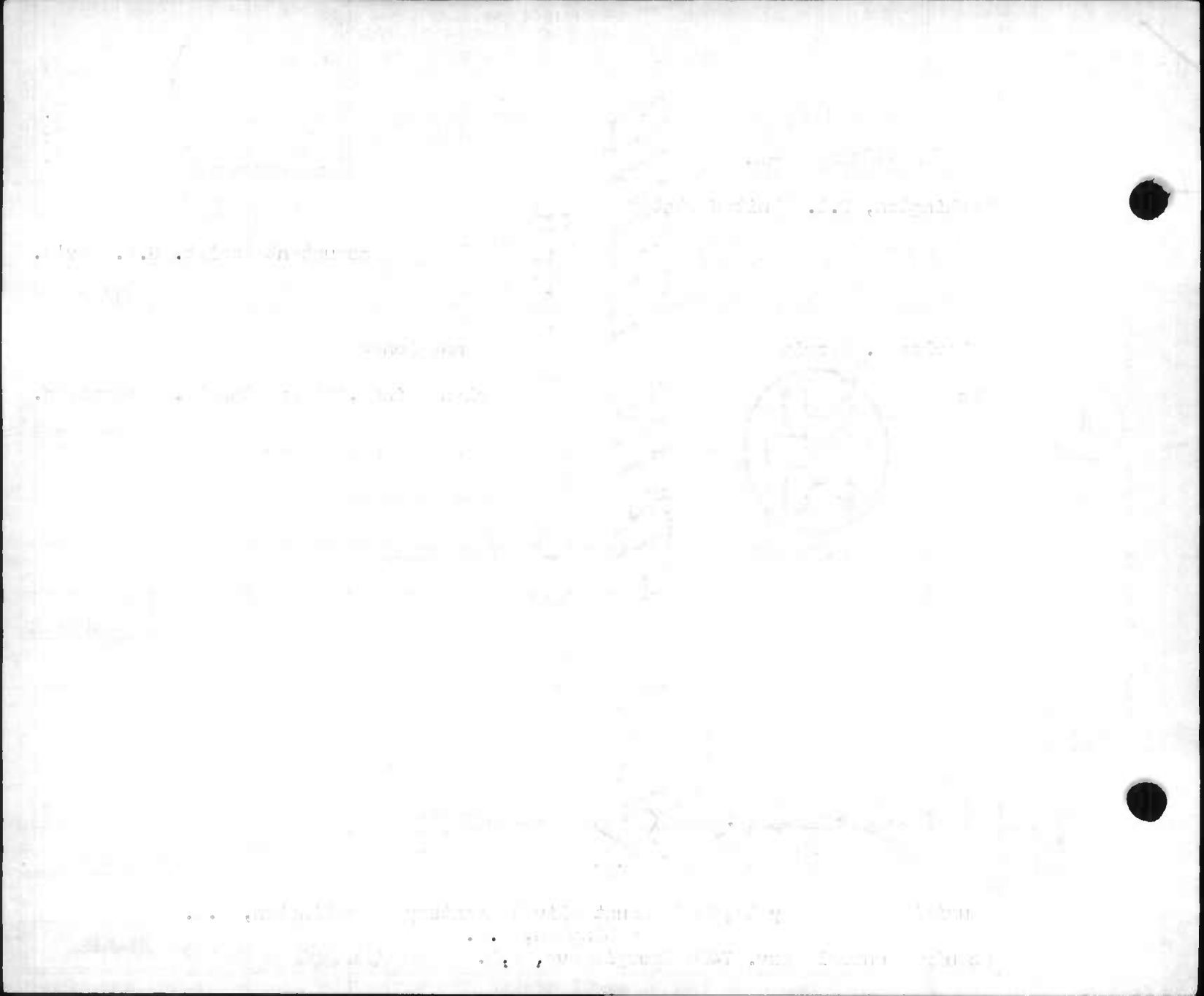
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS FORM IS TO BE FILED WITH THE MEDICAL EXAMINER'S RECORDS. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 MC (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614880

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsa R. Hobson			2a. DATE OF DEATH MONTH DAY YEAR April 26, 1986		2b. HOUR MIN 4:50p M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 28, 1904		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 81		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government				

13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Finckel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Eloise Alden		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 579-26-0918		17. INFORMANT ADDRESS Charles W. Claxon 6016 Cheshire Drive Bethesda, Maryland 20814 (Brother-in-Law)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) cutaneous-ventricular conduction defect		10 min	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: leukemia's disease			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Sept 15, 1978 to 26 Apr 1986 , that (I) (we) last saw the deceased alive on 15 Apr 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE John M. Wyman M.D.	

22c. DATE SIGNED April 27, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wyman M.D.	
22e. ADDRESS 7801 Norfolk Avenue Bethesda, Maryland 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	
23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Jana Davidson	

24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
7557 Wisconsin Avenue Bethesda, Maryland 20814		APR 29 1986			

26. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.	

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CHITTY V. LOM



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14881

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY J. HODGE			2a. DATE OF DEATH MONTH DAY YEAR 05 30 86		2b. HOUR 6:57 AM						
3. SEX MALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 05 12 44		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTG Co MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Staff Sgt.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Florida		13b. COUNTY Pasco		13c. CITY OR TOWN Zephyrhills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1557 Pine Street 34248			
14. FATHER'S NAME FIRST MIDDLE LAST William Hodge				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Tauscher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam		17. INFORMANT 1557 Pine Street Pearl Elberson Zephyrhills, Fla. 34248							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO, OR AS A CONSEQUENCE OF (b) Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 5/19 to 5/30 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raymond Bass				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-30-88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3941 Fernan Dr Wheaton, Md 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 06/03/86		23c. NAME OF CEMETERY OR CREMATORY Northern Va. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia					
24. FUNERAL DIRECTOR NAME John E. Hodge				3901 N. Fairfax Drive Arlington, Va. 22203		25. DATE OF REGISTRATION JUN 06 1988					

MEDICAL CERTIFICATION

Released by [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

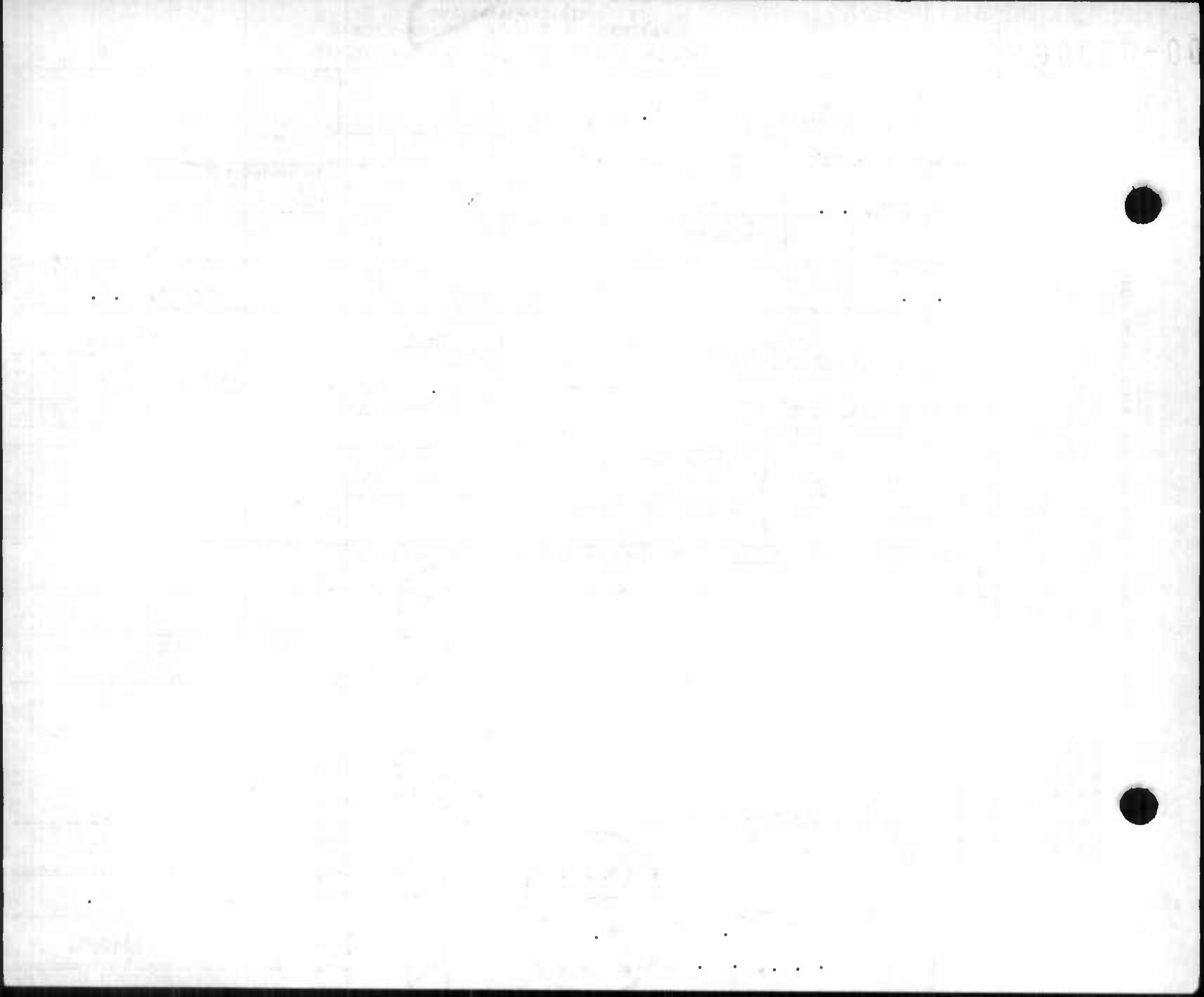
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00-05908

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4882	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY F. HOLLIMAN						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 1 19 86		2b. HOUR M 3:35 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 17 10		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 75		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 75 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 1 19 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) New Hampshire Ave. & Schindler Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Domestic, Governess			
13a. STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4309 13th Street, N.E.			
14. FATHER'S NAME FIRST MIDDLE LAST John Clark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Lipton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-22-2365		17. INFORMANT ADDRESS Mrs. Gertrude Marshall/daughter/					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS MIN. MONTH DAY YEAR 3:30 AM 5-1- 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck by truck while sitting at bus stop.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bus stop		21f. LOCATION STREET CITY OR TOWN COUNTY STATE New Hampshire Ave. & Schindler Rd., Silver Spring, Montgomery Co MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 5-2-86			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-8-86		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.			
24. FUNERAL DIRECTOR NAME John T. Rhines Co.				ADDRESS 3015 12th St. N.E., D. C. 20017				25a. DATE REC'D. BY REGISTRAR MAY 7 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	



00-06601

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 checked, any injury, or other traumatic event, the medical examiner should be notified and a post-mortem examination should be performed.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 8 8 3

1. DECEASED NAME (TYPE OR PRINT) Frances S. Holmead			2a. DATE OF DEATH MONTH DAY YEAR 5/8/86		2b. HOUR 3:09 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 7-11-07		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS	
7. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.-A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Senior High Sch.
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1403 Noyes Drive 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Strickland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Hilton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 218-34-5901		17. INFORMANT Daughter Gaithersburg, Md. Anne H. Dudley 19583 Transhire Road 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Bladder Cancer DUE TO, OR AS A CONSEQUENCE OF (c) 6 months			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 15 May 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 15 May 86 to 6 May 86 that (1) (we) last saw the deceased alive on 15 May 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Thomas A. Benninger MD		DEGREE MD		22c. DATE SIGNED 5/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER		22e. ADDRESS 7525 Greenway Ctr Dr. Greenbelt MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION CITY OR TOWN Washington, D.C.		23e. COUNTY 20817			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR MAY 15 1986			
25b. REGISTRAR'S SIGNATURE John A. Davidson					

Handwritten notes and signatures at the top of the page, including a large signature on the left and some illegible text on the right.

Handwritten notes and signatures in the middle section of the page, featuring several lines of cursive text and a signature.

Handwritten notes and signatures at the bottom of the page, including a signature and some illegible text.



10-08730

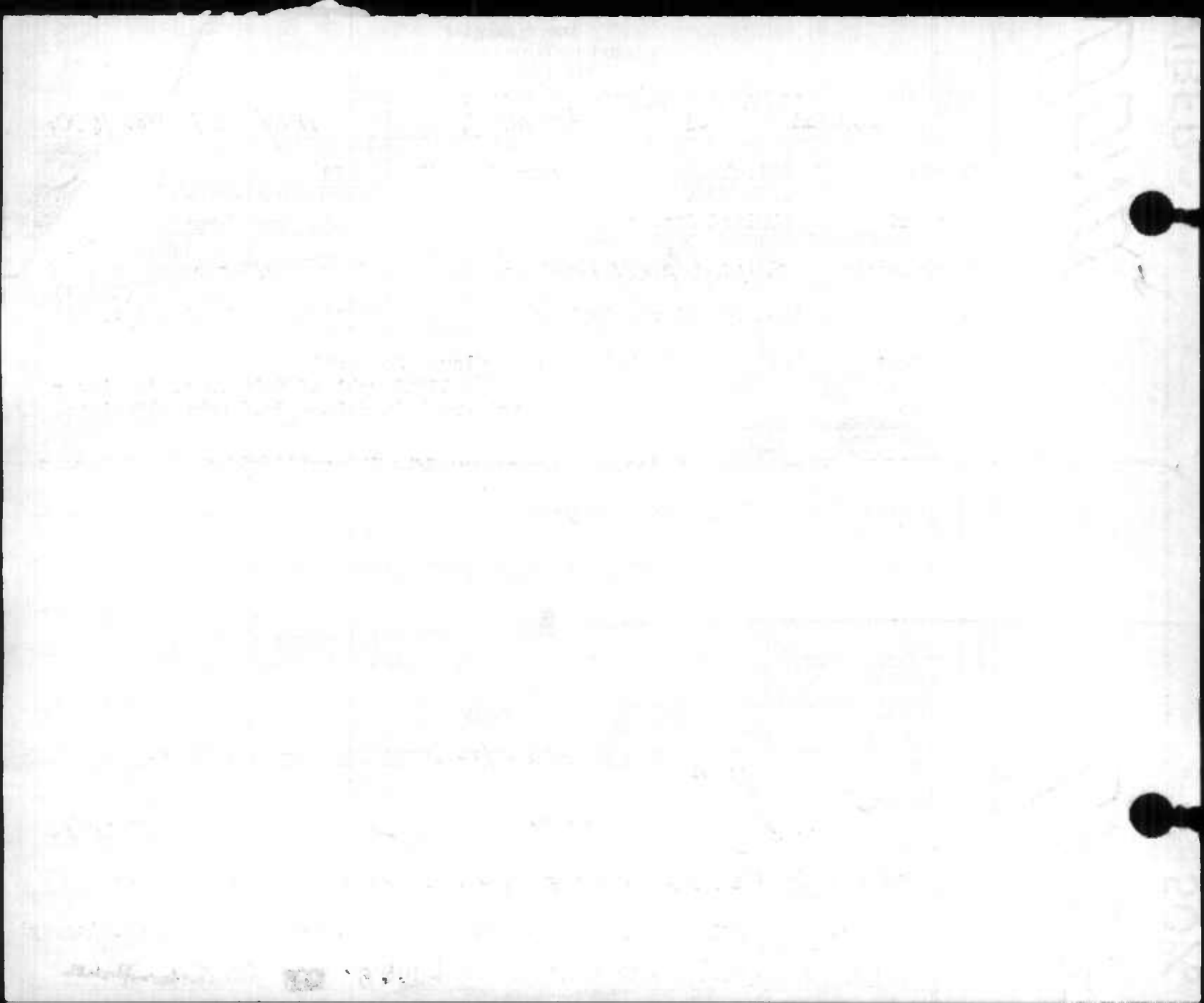
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6	1 4 8 8 4
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LINDA JO BEATTIE HOLMES						2a. DATE OF DEATH MONTH MAY DAY 27 YEAR 1986		2b. HOUR 1600 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH January DAY 18 YEAR 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GARDEN ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary/Temporary Research		12b. KIND OF BUSINESS OR INDUSTRY Co.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11215 Oakleaf Drive, Apt. 914 (20901)			
14. FATHER'S NAME FIRST Hubert MIDDLE Lee LAST Beattie				15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE Jo LAST Bell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 495-48-7610		17. INFORMANT 11215 Oakleaf Drive, Apt. 914, Silver Springs, Md. Earl Franklin Holmes, Jr. (husband)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 h -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/26/86 19 86 , to 5/27 19 86 , that (I) (we) lost saw the deceased alive on N/A 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIO D. BELLE DOWNE				22e. ADDRESS 14816 PHYSICIANS LANE 257							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/03/86		23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Joseph, Buchanan Co. Missouri					
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Georgia Avenue, N.W.; Washington, DC 20011				25a. DATE REC'D. BY REGISTRAR JUN 6 1986		25b. REGISTRAR'S SIGNATURE [Signature]					

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00-065971

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14885

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARJORIE E. HOOK		2a. DATE OF DEATH MONTH DAY YEAR 5 10-1986		2b. HOUR 11⁰⁰ A.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01-30-1898		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Benia NJ	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEI Pre Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hosp Admiss officer	
13a. STATE md	13b. COUNTY Montgomery	13c. CITY OR TOWN Olney	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Enderby	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Emma Hard		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 150-20-7425	17. INFORMANT ADDRESS MARILYN HOOK WILLIAMS, DAUGHTER, SAME AS ITEM 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

AsystoleAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Acute**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASAC?**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Chronic**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended deceased from May 7, 1986 to May 10, 1986 , that (I) (we) lost saw the deceased alive on May 7, 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Thomas E. Dorley, MD		22c. DATE SIGNED May 10, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dorley, MD		22e. ADDRESS 17904 Greenfield Road Olney, MD 20832	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 5/11/86	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W. WASHINGTON, D.C. 20009		25a. DATE REC'D. BY REGISTRAR MAY 15 1986	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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00-09199

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

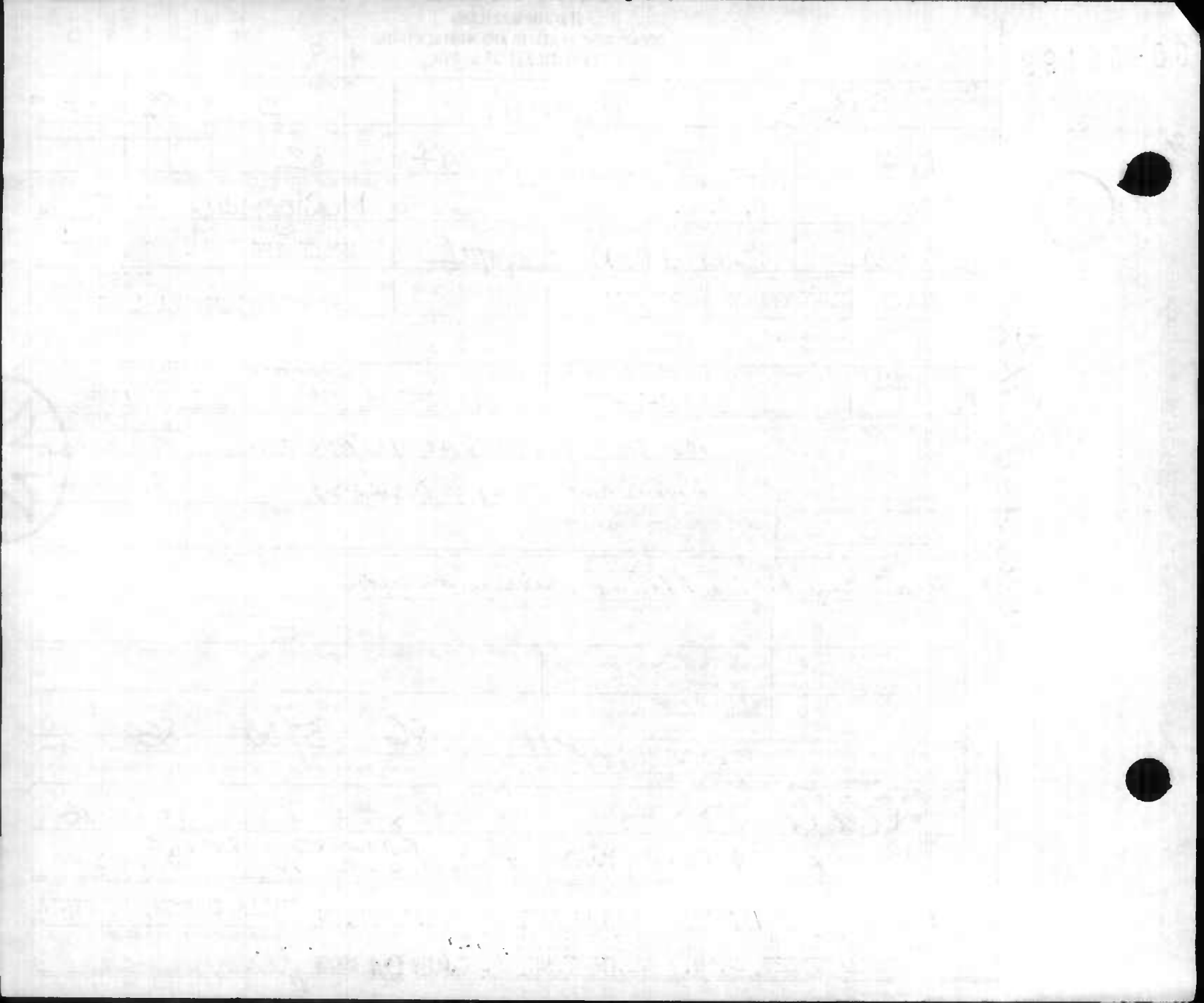
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rose Hoptman			2a. DATE OF DEATH MONTH DAY YEAR 5 30 86		2b. HOUR 12¹⁶ A		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 10 04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery COUNTY MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ISAAC^{1ST} HIRSCH^{MIDDLE} LERNER		15. MOTHER'S MAIDEN NAME SARAH^{1ST} MIDDLE ROSEN		13e. STREET ADDRESS / ZIP CODE 259 CONGRESSIONAL LANE 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 124-18-7772		17. INFORMANT ROCKVILLE, MARYLAND AARON HOPTMAN, 259 CONGRESSIONAL LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. one hour 2 years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic angiotensin heart failure, Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:15 2/15 86 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 86 5/30 86			
22a. I certify that (I) (this hospital) attended the deceased from 5/15 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. REISKIN, MD		22e. ADDRESS 20 W. ROBINSON DRIVE ROCKVILLE MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/1/1986		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR (NAME) DONALD M. STEIN		HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR JUN 04 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



00-06603

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS P. HORAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 10, 1986			2b. HOUR 1:00 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3104 Dawson Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost & Repair Analyst		12b. KIND OF BUSINESS OR INDUSTRY Maritime Admin.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3104 Dawson Avenue 20902	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Horan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Marcellus						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-03-8223		17. INFORMANT ADDRESS Grace H. Horan Wife Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corboret arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 years</u> <u>70 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 9</u> , 19 <u>86</u> , to <u>May 9</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>May 9</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael R. Dobridge</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/12/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael R. Dobridge, M.D.			22e. ADDRESS 13975 Connecticut Avenue Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 13, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			ADDRESS 500 University Blvd., W. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE <u>John Darden</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified to examine the body.



00-077931-

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Horton Lena			2a. DATE OF DEATH MONTH DAY YEAR 5-20-86			2b. HOUR 12 30 PM			
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 6 06		6. AGE (IN YEARS (LAST BIRTHDAY)) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5721 Grosvenor Lane 20814	
14. FATHER'S NAME FIRST MIDDLE LAST WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgina Taylor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
		16b. SOCIAL SECURITY NO. 577-24-5338		17. INFORMANT ADDRESS Isabelle Wright 5034 38th Ave. #4 Hyattsville, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory FailureAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**days**

DUE TO, OR AS A CONSEQUENCE OF

Chronic Obstructive Pulmonary Disease**years**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

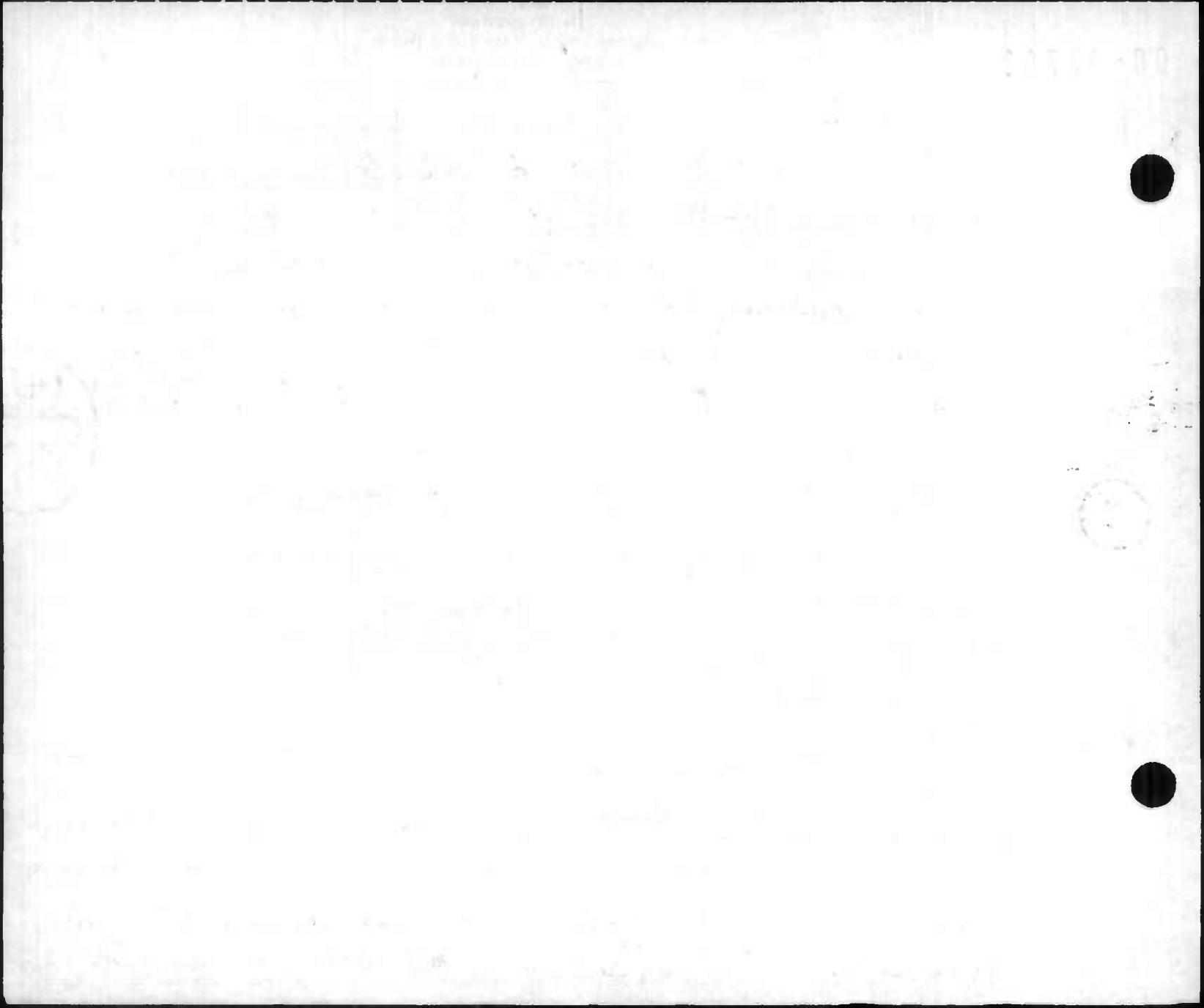
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1986 to May 20, 1986 , that (I) last saw the deceased alive on May 20, 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) and that (did not) view the body after death.							
22b. SIGNATURE Barry Heene				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Heene				22e. ADDRESS 3441 PENNARA DRIVE WHEATON, MD 20860			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/86		23c. NAME OF CEMETERY OR CREMATORY HARMONY Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, P.G., Md.	
24. FUNERAL DIRECTOR NAME HALL Bros.				25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodriguez	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-07651

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 8 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL M. HUGHES			2a. DATE OF DEATH MONTH DAY YEAR 5 16 86			2b. HOUR 545 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 15 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Federal Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 Russell Ave. 20760	
14. FATHER'S NAME FIRST MIDDLE LAST Harve Ricketts					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Cook				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT (Grandson) ADDRESS Mr. Van Doran Smith Bethesda, M.D. 20814					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperkalemia and Acidosis DUE TO, OR AS A CONSEQUENCE OF (b) of uncertain etiology DUE TO, OR AS A CONSEQUENCE OF (c) Myelofibrosis - Pulmonary Hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myelofibrosis - Pulmonary Hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5/16 19 86 to 5/16 19 86 , that (I) (we) last saw the deceased alive on 5/16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steve Newman						DEGREE MD		22c. DATE SIGNED 5/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Newman						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5-17-86		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002		
24. FUNERAL DIRECTOR NAME J. William Lee's Sons Company ADDRESS 300 4th Street, N.E. Washington, D.C. 20002						25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

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3000 + 700 = 3700
T. J. Jones & Co., Inc.
Washington, D.C.

00-06946

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-keepers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 8 9 0

1. DECEASED NAME (TYPE OR PRINT) SHERILL HUGHES			2a. DATE OF DEATH MONTH DAY YEAR 5-6-86		2b. HOUR 8:52 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR July 7, 1957	6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Word Processor	12b. KIND OF BUSINESS OR INDUSTRY Automated Signs Grp.	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Henry MIDDLE S. LAST Hughes			15. MOTHER'S MAIDEN NAME FIRST Hazel MIDDLE Washby LAST Washby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-94-9673		17. INFORMANT Hazel Hughes, 418 E. Liberty St., Charles Town, W.VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) End Stage renal failure (c) Septicemia - Serratia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (3) Coma secondary to cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus (poorly controlled) Sepsis disorder					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:16 P.M. 5/6 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5/6/1986	
22a. I certify that (I) (this hospital) attended the deceased from 5/6/1986 to 5/6/1986 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. A. Chock				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. A. CHACKO				22e. ADDRESS 8500, 16th St. Suite G-31 Silver Spring Md. 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-10-86		23c. NAME OF CEMETERY OR CREMATORY Pleasant View	
23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg, Berkeley, W. Va.		23e. DATE REC'D. BY REGISTRAR MAY 19 1986			
24. FUNERAL DIRECTOR NAME Strider Funeral Home P.O. Box 388 Charles Town, West Virginia					

BP

34230-00

Case

Handwritten notes and a large circular stamp in the upper left quadrant.



Handwritten notes and a large circular stamp in the lower left quadrant.

1951-1952

1953-1954

1955-1956

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

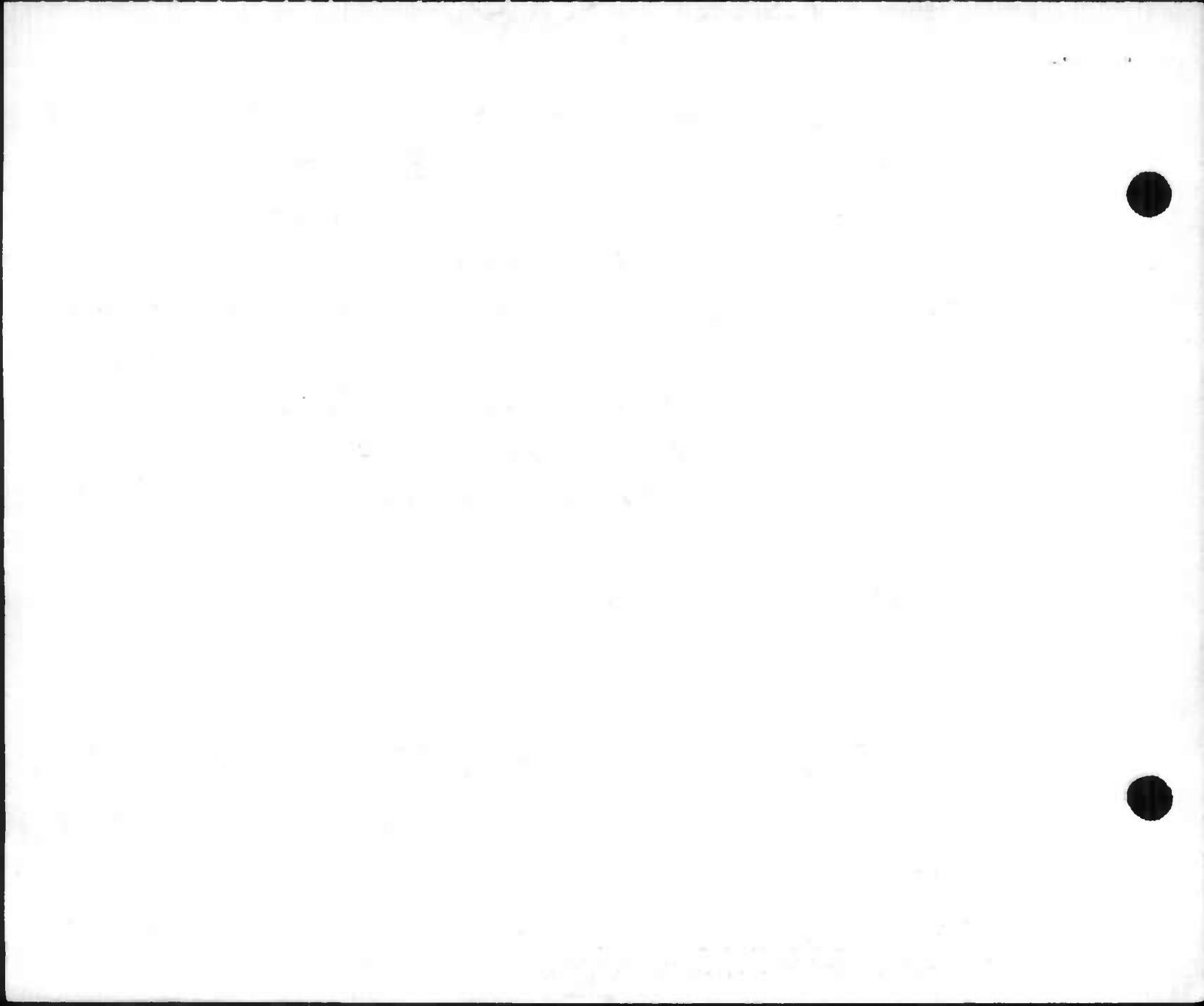
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				2b. HOUR	
Helen G. HUNLEY								5-29-86				2:10 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female	white		7 17 03		82		MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
wash D.C.		USA				montgomery						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		wheaton Manor Care		Homemaker									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		ZIP CODE			
md		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19310 Clubhouse Rd		20879			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
James Bell		Mamie Hines		No		579-20-0471		Son		4416 Mt. Olney Lane			
								William H. Hunley, Jr.		Olney, Md.		20832	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				Brain metastases		Colon Cancer				1 mo			
										8 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				Bone + Lung mets									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that (1) this hospital attended the deceased from		5/14/86		Jan 19 85		to 5/29/86		that (1) we last saw the deceased alive on		5/14/86		and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Peter Sherer		MD				5/29/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Peter Sherer MD		3947 ferrara Dr.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		June 2, 1986		Ft. Lincoln Cemetery		Brentwood Pr.		Geo. Maryland					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Francis J. Collins, Jr.		500 University Blvd. W., Silver Spring, Md.				JUN 4 1986		Julia Davidson Henderson					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06476

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 8 9 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES J HURLEY			2a. DATE OF DEATH MONTH DAY YEAR 5-6-86		2b. HOUR 3.04 P
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8-25-02		6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital			12a. USUAL OCCUPATION Custodian	12b. KIND OF BUSINESS OR INDUSTRY School System
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Prince George	13c. CITY OR TOWN Beltville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Patrick MIDDLE J. LAST Hurley			15. MOTHER'S MAIDEN NAME FIRST Ellen MIDDLE Howard LAST Howard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 014-01-3460		17. INFORMANT ADDRESS Peter Hurley Sameas #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 5/6 1986 , to 5/6 1986 , that (we) lost 0 saw the deceased alive on 5/6 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) see the body after death.					
22b. SIGNATURE Michael J. Koch		DEGREE MD		22c. DATE SIGNED 5/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Koch		22e. ADDRESS 2101 National Park Dr. Silver Spring MD 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-9-86	23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Prince George Md.	
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt				25a. DATE REC'D. BY REGISTRAR MAY 12 1986	
ADDRESS Beltville Md 20705				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-08163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86		14893			
1. FOR STATE REGISTRAR										REG. NO.					
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy V. Hynson</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>5-27-86</i>				2b. HOUR <i>5:40 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-25-1907</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Med. Adm. Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>NIH</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1816 Brisbane Street 20902</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Beall</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Charolotte Schultz</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>							
16b. SOCIAL SECURITY NO. <i>216-40-6871</i>				17. INFORMANT <i>Daughter</i> ADDRESS <i>10124 Pierce Drive Dolores A. Smith Silver Spring, Md. 20901</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aspiration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Aspiration</i> 18 hours 18 hours															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Alzheimer's disease</i>															
19a. DATE OF OPERATION <i>NOV 17 1986</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <i>NOV 17 1986</i> to <i>MAY 27 1986</i> , that (I) (we) last saw the deceased alive on <i>MAY 26 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Seruch T. Kimble M.D.</i>								DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5-27-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Seruch T. Kimble, M.D.</i>								22e. ADDRESS <i>9801 Georgia Ave Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>May 29, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery Adelphi, Pr. Geo. Maryland</i>				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>								25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>JUN 2 1986</i>							
500 University Blvd., W. Silver Spring, Md.															

BP



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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) VELMA MARRA INFANTE		2a. DATE OF DEATH MONTH DAY YEAR MAY - 2 - 86		2b. HOUR 5 50 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1917	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Frank --- Marra		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria --- Morasco		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-26-7781		17. INFORMANT ADDRESS Jose Infante, Same address as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Lymphangitic Spread. in Lung DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Breast					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 mo. 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1984 , 19____, to 5/2/86 , 19____, that (I) (we) lost saw the deceased alive on 5/2/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jeremy W. Cook		DEGREE MD		22c. DATE SIGNED 5/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy W. Cook		22e. ADDRESS 10400 Conn Ave. Kensington			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/5/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD		25a. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
24. FUNERAL DIRECTOR ADDRESS 5130 Wisconsin Ave. NW, Washington, D.C. 20016		MAY 07 1986			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 14894

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[illegible]

00-08156

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614895
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T. ISBELL			2a. DATE OF DEATH MONTH DAY YEAR 5 26 86		2b. HOUR 1PM		
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 12 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Allen Isbell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dacia White		13e. STREET ADDRESS / ZIP CODE 13211 Keating Street 20853			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 263-16-1829		17. INFORMANT Bertha F. Isbell Wife Same as 13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) clotrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Biventricular CHF, Spinal + aortic valve replacement, Arterio							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5-26-86 to 5-26-86 , that (we) last saw the deceased alive above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Kivak, Jr., M.D.				DEGREE MD		22c. DATE SIGNED 5-27-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN KIVAK, Jr., M.D.				22e. ADDRESS Silver Spring, Md. 344 University Blvd. West #112			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
500 University Blvd., W. Silver Spring, Md.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It may be removed from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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00-07144

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

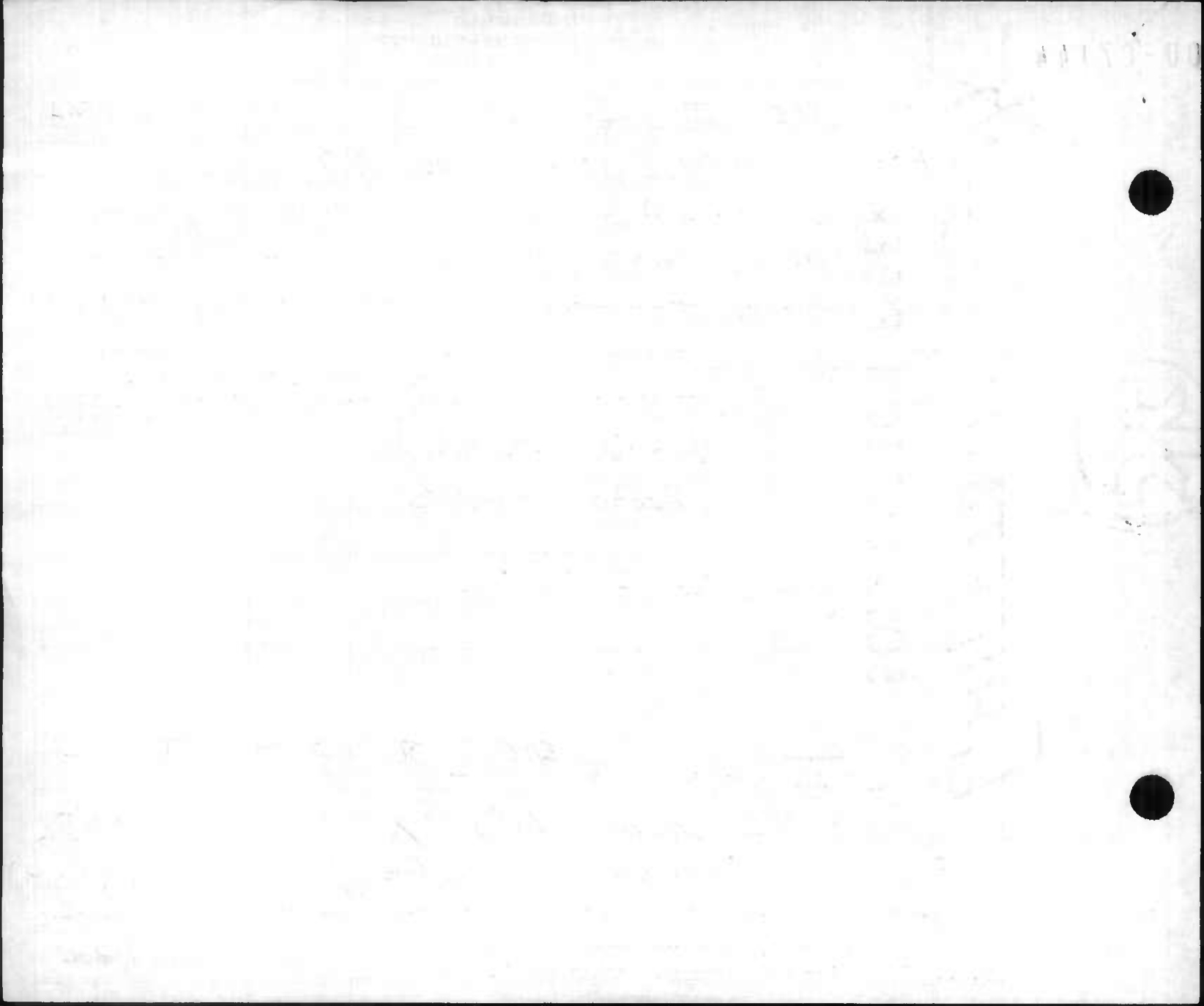
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614896

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FLORENCE J. JACOBS			2a. DATE OF DEATH MONTH DAY YEAR 05 17 86			2b. HOUR 9:54 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04 09 06		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Putnam			16. STREET ADDRESS / ZIP CODE 1316 Fenwick Lane #1415 / 20910			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) -		17. INFORMANT Mr. Thomas B. Jacobs, Son,		17. ADDRESS 4000 Dresden Street, Kensington, MD. 20895		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Congestive Heart Failure									
19a. DATE OF OPERATION 5/16			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 5/16 19 86 to 5/17 19 86 , that (I) (we) lost view the deceased alive on 5/16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank N. Gravano					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank N. Gravano					22e. ADDRESS 10313 Georgia Ave, Silver Spring, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD.					25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE J. Davidson		



00-07559

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8614897		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth F. Jarrett						2a. DATE OF DEATH MONTH DAY YEAR May 22, 1986		2b. HOUR 9:40a M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 30 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Red Cross	
13a. STATE Md.		13b. COUNTY Mtg.		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 Vantage Hill Court 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Edward S. Foster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katharine Larrabee		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 010-12-3909		17. INFORMANT ADDRESS 2210 2210 Fordham Dr. Alexandria, Va. Mr. Bill F. Jarrett							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Cardiac Myopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD, Kyphosis, Osteoporosis, Peripheral Vascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)					
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> 19 <u>May 21</u> 19 <u>86</u> , to <u>May 22</u> 19 <u>86</u> , that (I) (we) lost <u>above</u> , (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Oliver Lawless</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-22-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oliver Lawless, M.D.		22e. ADDRESS 15111 Prince Phillip Drive Olney MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-22-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

00-06273

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 4 8 9 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIE W. JEFFERSON			2a. DATE OF DEATH MONTH DAY YEAR 5-3-86		2b. HOUR 7:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-10-1888		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center 301 Russell Ave. Gaithersburg, Md. 20879		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Hackitt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-16-5681	
17. INFORMANT Margaret Tyler		18. ADDRESS Balto., Md. 21207		19. STREET ADDRESS / ZIP CODE Ashbury Meth. Home Gaith.		20. PHONE NO. 7209 Prince George Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Anterior wall Myocardial Infarction CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF OPERATION		21h. DATE OF INJURY	
22a. I certify that (I) did attend the deceased from 5/3/86 to 5/3/86 , that (I) was lost saw the deceased alive on 5/3/86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was not did not view the body after death.							
22b. SIGNATURE Ronald Gregg		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Gregg		22e. ADDRESS 12005 Darnestown Rd G.S. and		22f. DATE REC'D BY REGISTRAR MAY 9 8 1986		22g. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/6/86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalburg Caroline Md.	
24. FUNERAL DIRECTOR NAME Williamson Funeral Home		ADDRESS Federalburg, Md.		24a. DATE REC'D BY REGISTRAR MAY 9 8 1986		24b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-06938

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14899
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA A JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 5 13 86		2b. HOUR 7:15 ^A	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 20 1894		
6. AGE (IN YEARS LAST BIRTHDAY) 91		7. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 10705 Pebble Brook Lane 20854		
15. FATHER'S NAME FIRST MIDDLE LAST Unknown DePatie		16. SOCIAL SECURITY NO. 035 30 9459		17. INFORMANT Son Dr. Linwood H. Johnson, Jr. same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary ischemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate several years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) none		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from October 1975 to present 1986, that (I) (we) lost saw the deceased alive on Feb 20 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Allen J. Neill MD		DEGREE MD		22c. DATE SIGNED 5/13/1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. Neill MD		22e. ADDRESS 8601 116 Georgetown Rd. Bethesda Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE John Davidson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the container for the deceased and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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00-066607

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 9 0 0

1. DECEASED NAME (TYPE OR PRINT) George R. Johnson			2a. DATE OF DEATH MONTH May DAY 12 YEAR 1986			2b. HOUR 5:40 PM						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH July DAY 21 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9924 Silver Brook Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor			12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE Pennsylvania				13b. COUNTY Elk		13c. CITY OR TOWN Ridgway		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7 Day Street / 15853-9999		
14. FATHER'S NAME FIRST Peter MIDDLE LAST Johnson				15. MOTHER'S MAIDEN NAME FIRST Nellie MIDDLE LAST Nelson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 716 16 4925		17. INFORMANT ADDRESS Esther E. Johnson, wife, see #13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure		5 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis		many years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Pneumonia**

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 28, 1986 to present , that (I) (we) last saw the deceased alive on April 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allen J. O'Neill MD				DEGREE MD		22c. DATE SIGNED May 12, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. O'Neill MD				22e. ADDRESS 8601 Old Georgetown Rd, Bethesda MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Grassflat Lutheran		23d. LOCATION CITY OR TOWN Grassflat COUNTY Pennsylvania STATE 	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA ADDRESS 7557 Wisconsin Av., Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR MAY 15 1986 25b. REGISTRAR'S SIGNATURE John W. Davidson			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Described case to Dr. Robert, Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

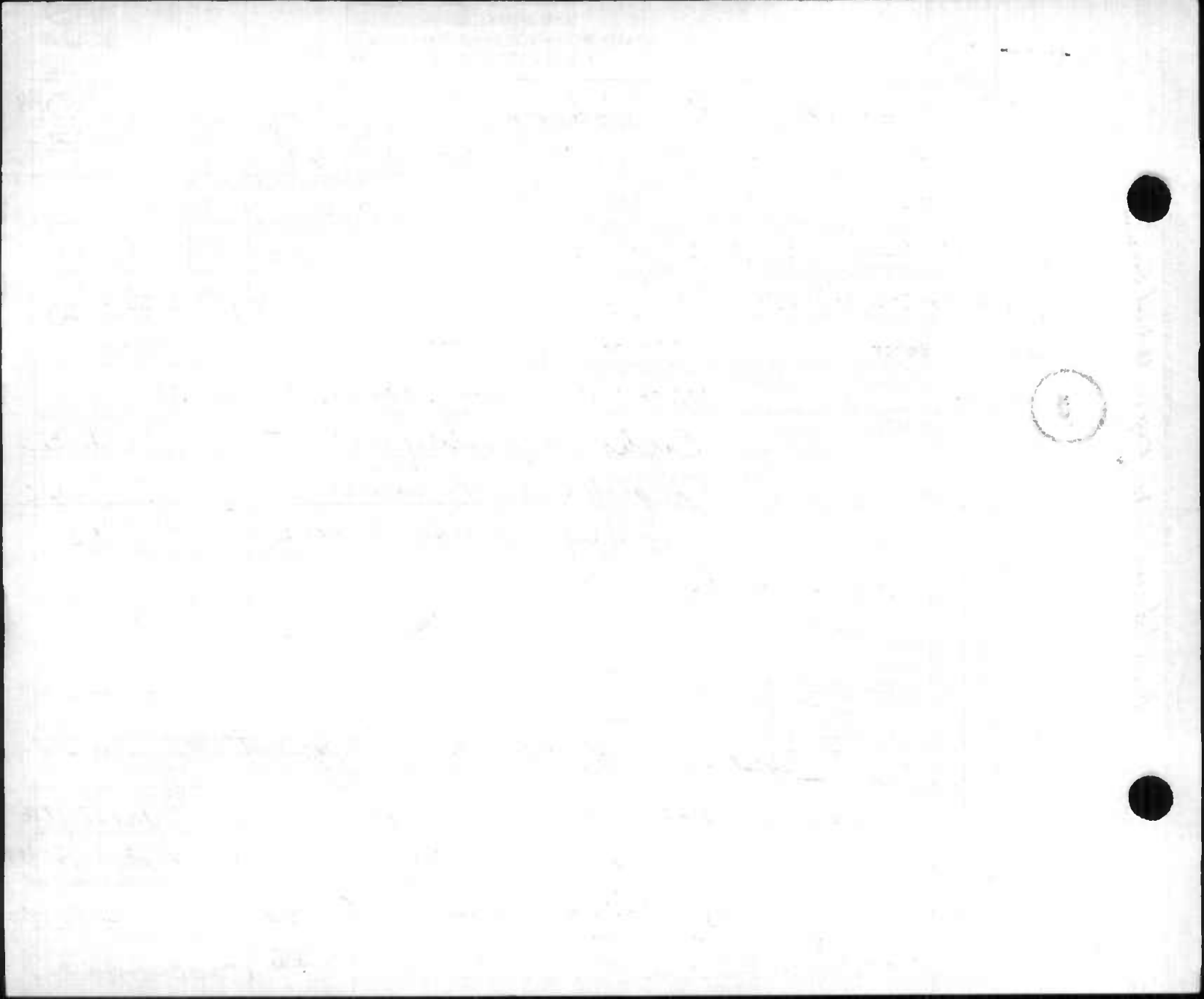
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DHMM - 10 60M 7/84
(VRA 15, 4)



00-09328

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Catlett Jones			2a. DATE OF DEATH MONTH DAY YEAR May 31, 1986		2b. HOUR 15:25P _M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR August 18 1924 ^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistical Clerk		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE D.C. Washington		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Dabney Catlett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Wesley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 578-32-6228	
17. INFORMANT ADDRESS John D. Jones 5740 3rd Street N.W. 20011		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hepatic failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>subarachnoid hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>prolonged thrombocytopenia, low platelet counts</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5740 3rd St. Montgomery MD.			
22a. I certify that (1) (this hospital) attended the deceased from 5/30/86 to 5/31/86, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Lewis Dennis MD</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Dennis MD		22e. ADDRESS 831 University Blvd. East Silver Spring, Maryland 20903					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 4 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS McGuire Funeral Service 7400 Georgia Ave. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR JUN 06 1986			
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pond</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

00-06654

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14902
REG. NO.1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles T Jones			2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 12 1986			2b. DATE OF ESTIMATION MONTH DAY YEAR May 12 1986		
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 23 1949	6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 12 1986	7d. DATE OF DEATH MONTH DAY YEAR May 12 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont		
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Ho sp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BAKERY		12b. KIND OF BUSINESS OR INDUSTRY SAFEMAN
13a. STATE Md			13b. COUNTY George		13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME (FIRST MIDDLE LAST) HOWARD JONES			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) BLANCHE CLARK			16. STREET ADDRESS 7333 N. Hampshire Ave		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-50-3757		17. INFORMANT RUTH E. JONES 7333 NEW HAMPSHIRE AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Duct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>								
19a. DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <u>[Signature]</u>			TITLE (SPECIFY) M.D. <u>[Signature]</u>			MEDICAL EXAMINER DATE SIGNED <u>May 21 1986</u>		
EXAMINER'S NAME (TYPE OR PRINT) J.B. JENKINS FUNERAL HOME			ADDRESS 7474 LANDOVER RD			23a. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK.		
23b. DATE 5-20-86			23c. LOCATION CITY OR TOWN LANDOVER, MD.			23d. LOCATION COUNTY STATE		
24. FUNERAL DIRECTOR NAME J.B. JENKINS FUNERAL HOME			ADDRESS 7474 LANDOVER RD			25a. DATE REC'D. BY REGISTRAR MAY 15 1986		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

37/84
25MDHMH - 17
(VR A15 ME (5))



00-07926

DIVISION OF VITAL RECORDS 101 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been reviewed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The physician's signature and the date of completion of the certificate should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

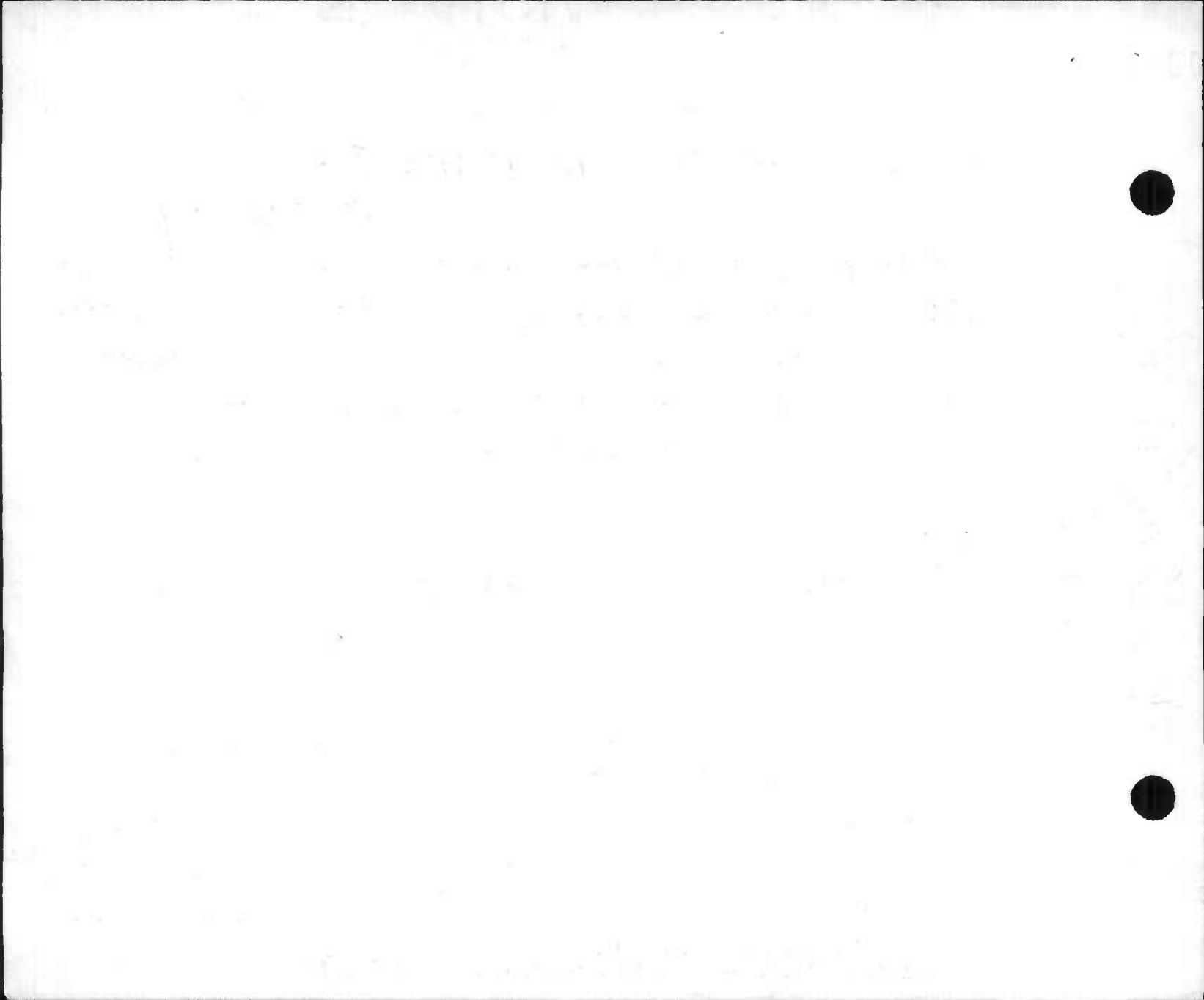
IMPORTANT: If item 21 is marked or item 18 shows any injury, either traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614903

1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST JAMES	MIDDLE W	LAST JONES	2a. DATE OF DEATH MONTH DAY YEAR 5 19 86		2b. HOUR 12:30 P.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 10 1903		6 AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Navy		12b. KIND OF BUSINESS OR INDUSTRY Military					
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7 E Melbourne Ave. 20901			
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Lane Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred L Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 577-48-7971		17. INFORMANT Laura D. Jones Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Meningeal metastases, Cerebellar, Cerebral Hemorrhage</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19 78</u> to <u>May 19 86</u> , that (I) (we) last saw the deceased alive on <u>May 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Blaine H. Eig</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE H. EIG		22e. ADDRESS 9801 George Lane Silver Spring, Md. 20902									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		23e. DATE REC'D. BY REGISTRAR MAY 28 1986			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		24b. ADDRESS 500 University Blvd. West Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 28 1986				25b. REGISTRAR'S SIGNATURE <u>James Warden</u>			

BP



00-09317

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6

1 4 9 0 4

1. DECEASED NAME (TYPE OR PRINT) KATHERINE FRANCES JONES			2a. DATE OF DEATH MONTH DAY YEAR MAY 25, 1986		2b. HOUR 4:15p M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1940		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX	13c. CITY OR TOWN ANNANDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7401 ENGLEWOOD PL. #10 22003
14. FATHER'S NAME FIRST MIDDLE LAST FRANK JOSEPH LOMEDICO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA COBERLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-38-4055		17. INFORMANT ADDRESS MR. JOHN K. JONES HUSBAND (SAME AS PATIENT)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEVERE PULMONARY CONGESTION WITH DENSE FIBROUS PLEURAL AND PERICARDIAL ADHESIONS. DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from JULY 10 , 19 84 , to MAY 25 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 25 , 19 86 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.					
22b. SIGNATURE <i>Paul Evans MD</i>				22c. DATE SIGNED 5/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. EVANS MD				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20892	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 29, 86		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR ARLINGTON FUNERAL HOME, 3901 N. FX. DR., ARL., VA		25a. DATE REC'D. BY REGISTRAR JUN 06 1986			
25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i>					

MEDICAL CERTIFICATION

29

1

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

999999

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
GENERAL AFFAIRS
FROM: [illegible]
SUBJECT: [illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text.]

00-06809

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugenia nmn Karydes						2a. DATE OF DEATH MONTH DAY YEAR May 12, 1986		2b. HOUR 9:00 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 199 Rollins Avenue #228				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 Rollins Ave. #228 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Morakis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stavroula Kakotilimeni					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 063-20-6321		17. INFORMANT ADDRESS John P. Stathes 1304 Crawford Dr. Rockville, Md 20851					
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Coronary Artery Disease over 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, severe over 15 yrs PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (Mrs. hospital) attended the deceased from Feb 7, 1950 to May 12, 1986 , that (I) (we) last saw the deceased alive on May 1, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Louis H. Shuman, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis H. Shuman, M.D.				22e. ADDRESS 10313 Georgia Ave., #107, Silver Spring, MD 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/86		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

00-08661

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

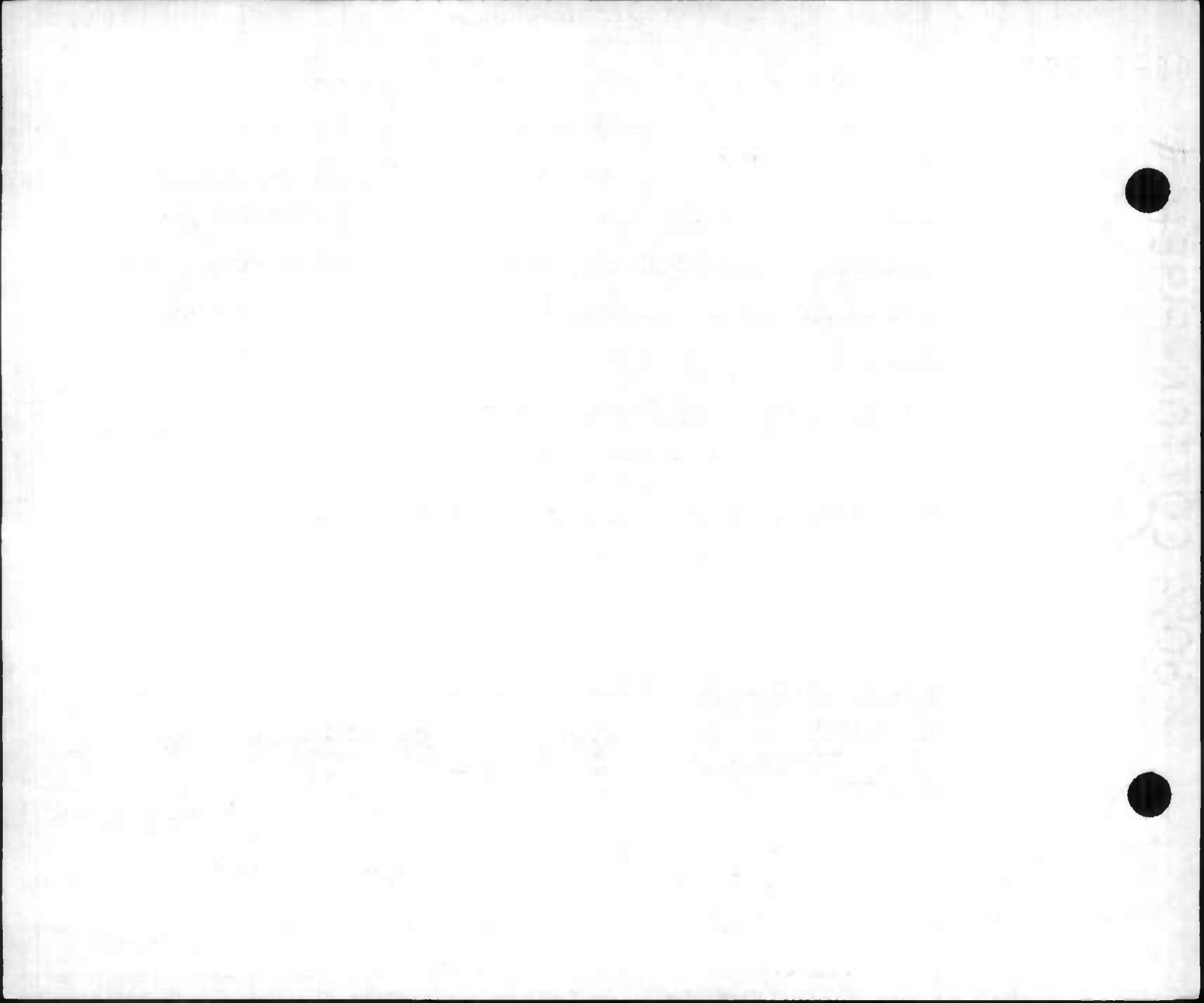
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 0 6

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha S. Kauffman			5 - 24 - 86			6:18 P.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 9, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STENOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		
13a. STATE VIRGINIA		13b. COUNTY ARLINGTON		13c. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4404- 4th ST., NORTH 99999		
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER -- SCHULTZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSIE --- DUEHRING			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
17. SOCIAL SECURITY NO. 578-32-0494			18. INFORMANT ADDRESS REV. DR. RICHARD REICHARD-NLH-ROCKVILLE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Clinical Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septic</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERSTANDING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE (IF FURTHER IN ITEM 18, PART 1 OR PART 2))				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (i) (this hospital) attended the deceased from May 24 19 81 to May 24 19 81 that (ii) (lost) saw the deceased alive on May 24 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.										
22b. SIGNATURE Thomas E. Dooley, M.D.			22c. DATE SIGNED May 25, 1981			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, M.D.				
22e. ADDRESS Rockville, Md 20850			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/28/1986			23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, MARYLAND	
24. FUNERAL DIRECTOR NAME HYSONG CO., INC.			24a. ADDRESS -1300 N ST., NW WASH., DC			25a. DATE REC'D. BY REGISTRAR JUN 02 1981			25b. REGISTRAR'S SIGNATURE Julia Davidson-Robert	



00-06465

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14907
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN PATRICK KEEGAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 7 1986		2b. HOUR P M 4:16 P
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 12 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE DELAWARE	13b. COUNTY SUSSEX	13c. CITY OR TOWN REHOBOTH BEACH	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10 COUNTRY CLUB 79999 19971	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WILLIAM KEEGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE CECILA MAGNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1967	17. INFORMANT ADDRESS KEVIN P. KEEGAN, 6210 BEACHWAY DRIVE, FALLS CHURCH, VA 22041			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GASTROINTESTINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 3 , 19 86 , to MAY 7 , 19 86 , that (I) (we) last saw the deceased alive on MAY 7 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>J.P. Mehegan</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>7/11/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MEHEGAN, LT, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05/12/86	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE West Hartford, Connecticut
24. FUNERAL DIRECTOR'S NAME Colonial Funeral Home		25a. DATE REC'D BY REGISTRAR MAY 13 1986	
6161 Leesburg Pike Falls Church, VA 22044		REGISTRAR'S SIGNATURE <i>John Davidson-Rodriguez</i>	

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-0687

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14908	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) David Joseph Kefauver										2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 15 1986	
2b. DATE OF DEATH MONTH DAY YEAR May 15 1986										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 15 1986	
3. SEX M										4. RACE W	
5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1953										6. AGE (IN YEARS) YEARS MONTHS DAYS 32 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC										7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver										12b. KIND OF BUSINESS OR INDUSTRY Delivery Ser.	
13a. STATE MD										13b. COUNTY Montgomery	
13c. CITY OR TOWN College Park										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4514 Albion Road/20740											
14. FATHER'S NAME FIRST MIDDLE LAST David F. Kefauver										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ball	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. ---	
17. INFORMANT Margaret B. Kefauver, Same address as #13										ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drug Overdose DUE TO, OR AS A CONSEQUENCE OF: (b) --- DUE TO, OR AS A CONSEQUENCE OF: (c) --- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 7 19 86	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Overdose PCP Alcohol Cocaine Amyl Nitrite										21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Georgia Ave. Silver Spring Montg. MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE John S. Rogers M.D. Cap TITLE (SPECIFY) MEDICAL EXAMINER										DATE SIGNED May 16 1986	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers										ADDRESS Silver Spring, Montg. Co., MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation										23b. DATE 5/13/86	
23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory										23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA	
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016										25a. DATE REC'D. BY REGISTRAR MAY 16 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

00-1111

Delaware

David

Joseph

X

USA

Washington, DC

Driver

X

Bill

--

Delaware

Delaware

F.

David

Ho



Myrtle A. Delaware, same address as Bill

Silver Spring, Mont. Co., MD

John B. Rogers

Alexandria, VA

Wt. Cont. at University

7/17/56

Greenham

Joseph Gowler's Sons, Inc.

2130 Wisconsin Ave., NW, Washington, D.C. 20036

0-058-13

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14909
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arlene S. Kettler			2a. DATE OF DEATH MONTH DAY YEAR May 2, 1986		2b. HOUR 7²⁵ PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06-09-08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTRY Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Nurse	12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE MD	13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1131 Univ Blvd West 20908	
14. FATHER'S NAME FIRST MIDDLE LAST (Unobtainable)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unobtainable)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 217-52-6472	17. INFORMANT ADDRESS Howard L. Stern, Atty.- 5711 Allentown Rd. Camp Springs, Md. 20746			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) circulatory and respiratory failure 1 day DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock 1 day DUE TO, OR AS A CONSEQUENCE OF (c) Acute myelogenous leukemia 3 months.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: arteriosclerotic heart disease congestive heart failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 5-2 19 86 , that (I) (we) lost saw the deceased alive on 5-2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Tung P. Lee MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/3/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TUNG P. LEE MD		22e. ADDRESS 7411 Riggs Road Hyattsville MD 20783			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE May 4, 1986	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR May 6 1986 25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1647-01

0-06195

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laguadra Tanika Kidd		2a. DATE OF DEATH MONTH DAY YEAR 5/5/86		2b. HOUR 8 A.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5/5/86	
6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 55		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —	
12b. KIND OF BUSINESS OR INDUSTRY —		13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 605 Cannon St / 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Lonnie Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yvette Kidd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Yvette Kidd 605 Cannon Road Silver Spring, Md. 20904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE IMMATURITY (21 weeks fetus) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) —					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 5/5/86 to 5/5/86 , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE A. Gebre Selassie	
22c. DATE SIGNED 5/5/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. GEBRESELASSIE		22e. ADDRESS 2426 Ross Road, S.S. Md 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		25. DATE REC'D. BY REGISTRAR MAY 27 1986	
25b. REGISTRAR'S SIGNATURE —		25c. REGISTRAR'S NAME —		25d. REGISTRAR'S TITLE —	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

00-07407

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach this page to the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma to the body, the medical examiner or the medical examiner's representative must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14911
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST		5-20-86		7:30 P M	
Thomas		Kiernan			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	White	MONTH DAY YEAR	75 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts	USA		montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE WORKER, NAME OF WORKING FIRM)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Bethesda ACC-2601 Bethesda Rd.	Director of Ins.	VA. Adm.		
13a. STATE	13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE			
MD	Montgomery Rockville	13835 Dowlais Drive 20853			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
John	Mary	Quinlan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
yes	1943-1945	Eileen P. Kiernan-wife-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) ALZHEIMERS DISEASE					
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROTIC VASC. DIS.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
HYPERTENSION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 19, 1986, to MAY 20, 1986, that (we) last saw the deceased alive on MAY 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED		
Bernard A. Fitzgerald MD			5-20-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
BERNARD A. FITZGERALD	217 UNIVERSITY BLVD EAST SILVER SPRING, MD 20901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	May 27, 1986	St. Josephs Cemetery	BOSTON COUNTY STATE		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.		MAY 22 1986		[Signature]	



00-07002

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614912

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maybelle H. King			2a. DATE OF DEATH MONTH DAY YEAR May 18 1986			2b. HOUR 3:36 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 19 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1201 Harding Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1201 Harding Lane 20904	
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14. FATHER'S NAME FIRST MIDDLE LAST Henry Wiethop				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Tebbe			
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Carole A. Sansone-daughter-Silver Spring, Md. 20904	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>WIDE SPREAD METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>9 MO</u> <u>2 YRS</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PARTIAL BOWEL OBSTRUCTION</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>86</u> , to <u>5/18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
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22b. SIGNATURE <u>Richard P. Delaney</u> DEGREE				22c. DATE SIGNED <u>5/19/86</u>			
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.				22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906			
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-21-1986		23c. NAME OF CEMETERY OR CREMATORY Maryland National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Prince Georges Md.	
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24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbonpapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06279

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8614913	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Cordilla Nora Knott		May 4 '86					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White		June 22 1908		77 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Germantown		19908 Waterloo Ct.		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Montgomery		Germantown				19908 Waterloo Ct. (20874)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Robert		Mary		No		214-01-5833D		Mary Helen Harwell			
		Childress						19908 Waterloo Ct., Germantown, Md. 20874			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion											
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma of Breast											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 5/6/86 to 5/6/86, that (I) (we) lost saw the deceased alive on 5/6/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Hiru Khianey, M.D.		5/5/86		20428 Germantown Rd., Germantown, Md. 20874							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5/6/86		Forest Oak Cemetery		Gaithersburg Montg. Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Gartner Sandison F. H.		MAY 08 1986		John Davidson-Randall							

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00-08308

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the appropriate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by you.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614914

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stefan G. Knudson			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1986			2b. HOUR 9:50AM					
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR November 27, 1972		6 AGE (IN YEARS LAST BIRTHDAY) 13 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			12b. KIND OF BUSINESS OR INDUSTRY Student Education		
10 CITY OR TOWN OF DEATH Clarksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12409 Dancrest Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12409 Dancrest Drive / 20871			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Joseph Knudson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gabriele Ilse							
16a. WAS DECEASED EVER IN ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (YES, NO OR UNKNOWN) None		17 INFORMANT C. Joseph Knudson (father) same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diseased / leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bone Marrow Transplant / Ablative therapy</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 months</u> <u>14 months</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Neuroblastoma</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Jan 86</u> to <u>May 28</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Jan 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>(Note: I have been in weekly phone contact with)</u>											
22b. SIGNATURE <u>Lawrence F. Cohen M.D.</u>		22c. ADDRESS 20902 10313 Georgia Ave. #303 Silver Spring, Md.		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence F. Cohen, M.D.		22e. ADDRESS 20902 10313 Georgia Ave. #303 Silver Spring, Md.		22f. DATE SIGNED 5/28/86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 31, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 3 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14915
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WILLIAM		MIDDLE NMN		LAST KOLA		5/22/86 4:20 AM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2/05/12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OR GIVE YOUR MOST OF WORKING LIFE) SALES		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. RESIDENCE GEORGE'S		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME HORACE		15. MOTHER'S MAIDEN NAME FANNIE		13e. STREET ADDRESS / ZIP CODE 6912 WEST PARK DRIVE 20783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-05-3545		17. INFORMANT RUBY L. KOLA, 6912 WEST PARK DRIVE HYATTSVILLE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> 13yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Patricia A Gurny</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A GURNY, M.D.		22e. ADDRESS 11161 NEW HAMPSHIRE AVENUE, SILVER SPRING MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 5/23/1986		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY ADELPHI, GEORGE'S		23d. LOCATION PRINCE GEORGE'S, MARYLAND	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25. DATE REC'D BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE <i>J. A. Davidson-Randall</i>			

MEDICAL CERTIFICATION

20% COLLECTIBLE



00-06365

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8614916 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stavros Dennis Kominos					2a. DATE OF DEATH MONTH DAY YEAR MAY 7 1986			2b. HOUR 3:00P. M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 10, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 20322 Thunderhead Way / 20874	
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Kominos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theodora Kalogiris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - 080-28-1822		17. INFORMANT ADDRESS Mrs. Aphrodite Kominos, Wife, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> 912 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Brain stem Infarcts</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes, Lung Cancer, COPD, Congestive Heart Failure, Rheumatoid Arthritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> 19 <u>87</u> to <u>THAT</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/1/86</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Douglas R. Shumaker, MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/7/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DOUGLAS R SHUMAKER, MD</u>					22e. ADDRESS <u>615 W. MONTGOMERY AVE. ROCKVILLE, MD 20850</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Avenue, Rockville, MD.					25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <u>Wm Davidson Anderson</u>		

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00-06222

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14917
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ralph Wesley Krause</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 6 1986</i>			2b. HOUR <i>1:40 A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 18 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3477 S. Liesure World Boulevard</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Printer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>G.P.O.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Same As 11 20906</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William M Krause</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth R Munro</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578-07-4067</i>		17. INFORMANT ADDRESS <i>Mary L. Krause Wife Same As 11</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma, primary unknown</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Bone and liver metastases of adenocarcinoma. Terminal coma. Possible brain metastases.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <i>1 May 1986</i> to <i>6 May 1986</i> that (I) (we) last saw the deceased alive on <i>1 May 1986</i> and that in (my) team's opinion death occurred on the date and hour and from the causes stated above. (I) was told (did not) view the body after death.									
22b. SIGNATURE <i>Donald E. Dill MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6 May 86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 9, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Montgomery Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 12 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
500 University Boulevard W. Silver Spring, Md.									

MEDICAL CERTIFICATION

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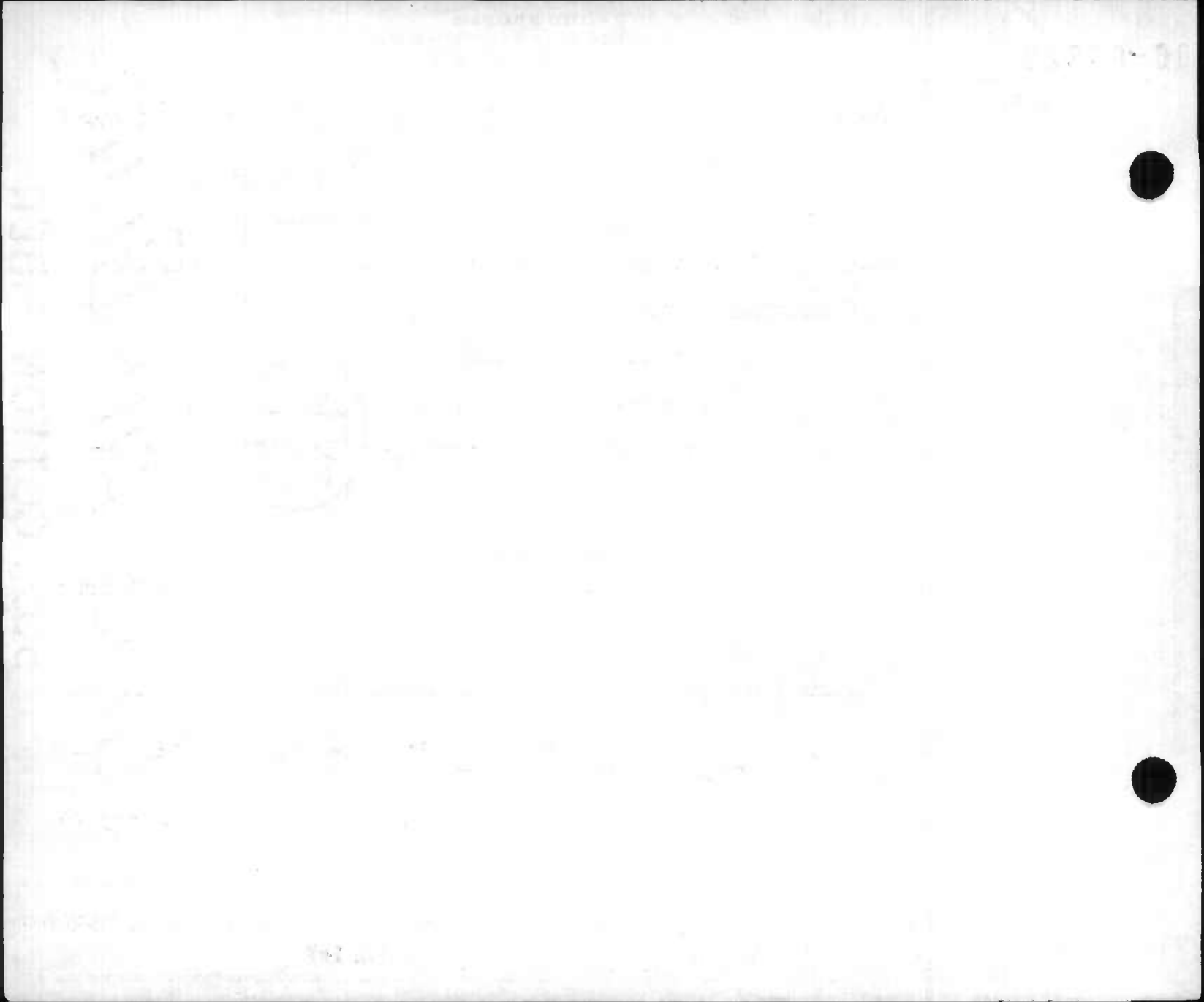
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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8/19/86

DIVISION OF VITAL RECORDS, 201 PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))
20M 4/82

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14918			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TEDDY LYNN KRUEGER										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-25-86		2b. HOUR M 7:30a	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 24, 1944		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 42 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-25-86		7d. HOUR M 7:30a			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH Poolesville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17431 Hughes Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electrical			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Jo Edward John Krueger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Lou Courtney				13e. STREET ADDRESS 17431 Hughes Road 20837					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam		17. INFORMANT Gerry Wilk same as 13e				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drug Abuse (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? (morbid condition)						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant				DATE 5-26-86					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/31/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Hampton, Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852						25. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE Wardson Hordess					

DHMH - 17
(VR A15 ME (5))
20M 4/82

10-10-10

10-10-10

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00-06468

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14919

1. DECEASED NAME (TYPE OR PRINT) SIMON BENJAMIN LABE			2a. DATE OF DEATH MONTH DAY YEAR MAY 6 1986		2b. HOUR P 5:25 P M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 24 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		
13c. CITY OR TOWN VIENNA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 10190 CEDAR POND DRIVE 22180			99999		
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS LABE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE HILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1936-1965		17. INFORMANT ADDRESS MARGARET H. LABE, 10190 CEDAR POND DRIVE,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 3 19 86, to MAY 6 19 86, that (I) (we) last saw the deceased alive on MAY 6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. M. Guinee</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. GUINEE, LCDR, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/86		23c. NAME OF CEMETERY OR CREMATORY Fairfax Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Va.		24. FUNERAL DIRECTOR Murphy Funeral Home/4510 Wilson Blvd. Arlington, VA.			
25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

62-88-10



00-07121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14920

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilfred Lawrie		2a. DATE OF DEATH MONTH DAY YEAR 5 17 86		2b. HOUR 2:41 AM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 14 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? BRITISH		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY WORLD BANK			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1220 BLAIR MILL RD 20910			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE LAWRIE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET GRIFFITHS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-86-3741		17. INFORMANT ADDRESS DOROTHY LAWRIE, WIFE, SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung dz					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Coronary artery disease & CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-10-86 to 5-17-86 , that (I) (we) last saw the deceased alive on 5-15-86 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles M. Benner		DEGREE		22c. DATE SIGNED 5-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES M. BENNER, M.D.		22e. ADDRESS 11161 NEW HAMPSHIRE AVE., SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/18/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA					
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 20 1986			

BP



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00-08485

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 14921							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDA LAZDINS										2a. DATE OF DEATH MONTH DAY YEAR 5 29 86		2b. HOUR 9:00 AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 - 25 1902		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LATVIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.											
10. CITY OR TOWN OF DEATH TAKOMA PK, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP, Takoma PK, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY Publishing Co.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD										13b. COUNTY PG		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2303 RITTENHOUSE ST. 20782	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS 577-46-9578 THELMA M. SWEENEY (SAME AS #13)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Profound Hypotension DUE TO, OR AS A CONSEQUENCE OF (b) Acidosis DUE TO, OR AS A CONSEQUENCE OF (c) Perforation necrosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 98 hours 48 hours 48 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from JAN - 1 19 85, to MAY 29 19 86, that (I) (we) lost saw the deceased alive on MAY 28 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Patricia Gurny MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/29/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA GURNY						22e. ADDRESS 1161 NEW HAMPSHIRE AVE S.S. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 5-30-1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. Md.									
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.						ADDRESS RIVERDALE, Md.		25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

1. NAME (Last, First, Middle Initial)		2. GRADE		3. BRANCH		4. TITLE	
5. ADDRESS		6. CITY		7. STATE		8. ZIP	
9. PHONE		10. FAX		11. E-MAIL		12. OTHER	
13. DATE		14. TIME		15. DAY		16. MONTH	
17. YEAR		18. HOUR		19. MINUTE		20. SECOND	
21. DAY		22. MONTH		23. YEAR		24. TIME	
25. DATE		26. TIME		27. DAY		28. MONTH	
29. YEAR		30. HOUR		31. MINUTE		32. SECOND	
33. DAY		34. MONTH		35. YEAR		36. TIME	
37. DATE		38. TIME		39. DAY		40. MONTH	
41. YEAR		42. HOUR		43. MINUTE		44. SECOND	
45. DAY		46. MONTH		47. YEAR		48. TIME	
49. DATE		50. TIME		51. DAY		52. MONTH	
53. YEAR		54. HOUR		55. MINUTE		56. SECOND	
57. DAY		58. MONTH		59. YEAR		60. TIME	
61. DATE		62. TIME		63. DAY		64. MONTH	
65. YEAR		66. HOUR		67. MINUTE		68. SECOND	
69. DAY		70. MONTH		71. YEAR		72. TIME	
73. DATE		74. TIME		75. DAY		76. MONTH	
77. YEAR		78. HOUR		79. MINUTE		80. SECOND	
81. DAY		82. MONTH		83. YEAR		84. TIME	
85. DATE		86. TIME		87. DAY		88. MONTH	
89. YEAR		90. HOUR		91. MINUTE		92. SECOND	
93. DAY		94. MONTH		95. YEAR		96. TIME	
97. DATE		98. TIME		99. DAY		100. MONTH	
101. YEAR		102. HOUR		103. MINUTE		104. SECOND	
105. DAY		106. MONTH		107. YEAR		108. TIME	
109. DATE		110. TIME		111. DAY		112. MONTH	
113. YEAR		114. HOUR		115. MINUTE		116. SECOND	
117. DAY		118. MONTH		119. YEAR		120. TIME	
121. DATE		122. TIME		123. DAY		124. MONTH	
125. YEAR		126. HOUR		127. MINUTE		128. SECOND	
129. DAY		130. MONTH		131. YEAR		132. TIME	
133. DATE		134. TIME		135. DAY		136. MONTH	
137. YEAR		138. HOUR		139. MINUTE		140. SECOND	
141. DAY		142. MONTH		143. YEAR		144. TIME	
145. DATE		146. TIME		147. DAY		148. MONTH	
149. YEAR		150. HOUR		151. MINUTE		152. SECOND	
153. DAY		154. MONTH		155. YEAR		156. TIME	
157. DATE		158. TIME		159. DAY		160. MONTH	
161. YEAR		162. HOUR		163. MINUTE		164. SECOND	
165. DAY		166. MONTH		167. YEAR		168. TIME	
169. DATE		170. TIME		171. DAY		172. MONTH	
173. YEAR		174. HOUR		175. MINUTE		176. SECOND	
177. DAY		178. MONTH		179. YEAR		180. TIME	
181. DATE		182. TIME		183. DAY		184. MONTH	
185. YEAR		186. HOUR		187. MINUTE		188. SECOND	
189. DAY		190. MONTH		191. YEAR		192. TIME	
193. DATE		194. TIME		195. DAY		196. MONTH	
197. YEAR		198. HOUR		199. MINUTE		200. SECOND	
201. DAY		202. MONTH		203. YEAR		204. TIME	
205. DATE		206. TIME		207. DAY		208. MONTH	
209. YEAR		210. HOUR		211. MINUTE		212. SECOND	
213. DAY		214. MONTH		215. YEAR		216. TIME	
217. DATE		218. TIME		219. DAY		220. MONTH	
221. YEAR		222. HOUR		223. MINUTE		224. SECOND	
225. DAY		226. MONTH		227. YEAR		228. TIME	
229. DATE		230. TIME		231. DAY		232. MONTH	
233. YEAR		234. HOUR		235. MINUTE		236. SECOND	
237. DAY		238. MONTH		239. YEAR		240. TIME	
241. DATE		242. TIME		243. DAY		244. MONTH	
245. YEAR		246. HOUR		247. MINUTE		248. SECOND	
249. DAY		250. MONTH		251. YEAR		252. TIME	
253. DATE		254. TIME		255. DAY		256. MONTH	
257. YEAR		258. HOUR		259. MINUTE		260. SECOND	
261. DAY		262. MONTH		263. YEAR		264. TIME	
265. DATE		266. TIME		267. DAY		268. MONTH	
269. YEAR		270. HOUR		271. MINUTE		272. SECOND	
273. DAY		274. MONTH		275. YEAR		276. TIME	
277. DATE		278. TIME		279. DAY		280. MONTH	
281. YEAR		282. HOUR		283. MINUTE		284. SECOND	
285. DAY		286. MONTH		287. YEAR		288. TIME	
289. DATE		290. TIME		291. DAY		292. MONTH	
293. YEAR		294. HOUR		295. MINUTE		296. SECOND	
297. DAY		298. MONTH		299. YEAR		300. TIME	

00-06896

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM H. LEAHY			2a. DATE OF DEATH MONTH DAY YEAR MAY 12 1986		2b. HOUR 7:30A M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 116 Summerfield Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Rear Adm.		12b. KIND OF BUSINESS OR INDUSTRY US Navy
13a. STATE MD		13b. COUNTY Montg.	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 116 Summerfield Rd./20815
14. FATHER'S NAME FIRST MIDDLE LAST William D. Leahy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Tennant Harrington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1922-1966 212-38-6764		17. INFORMANT Robert B. Leahy, Chevy Chase, MD 20815	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH , 19 86 , to APRIL , 19 86 , that (I) (we) last saw the deceased alive on MAY , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David Cook MD		DEGREE		22c. DATE SIGNED 12 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID COOK, MD, LT, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

MEDICAL CERTIFICATION

Dr. F. Mayle, Deputy Med. Exam., notified and approved.

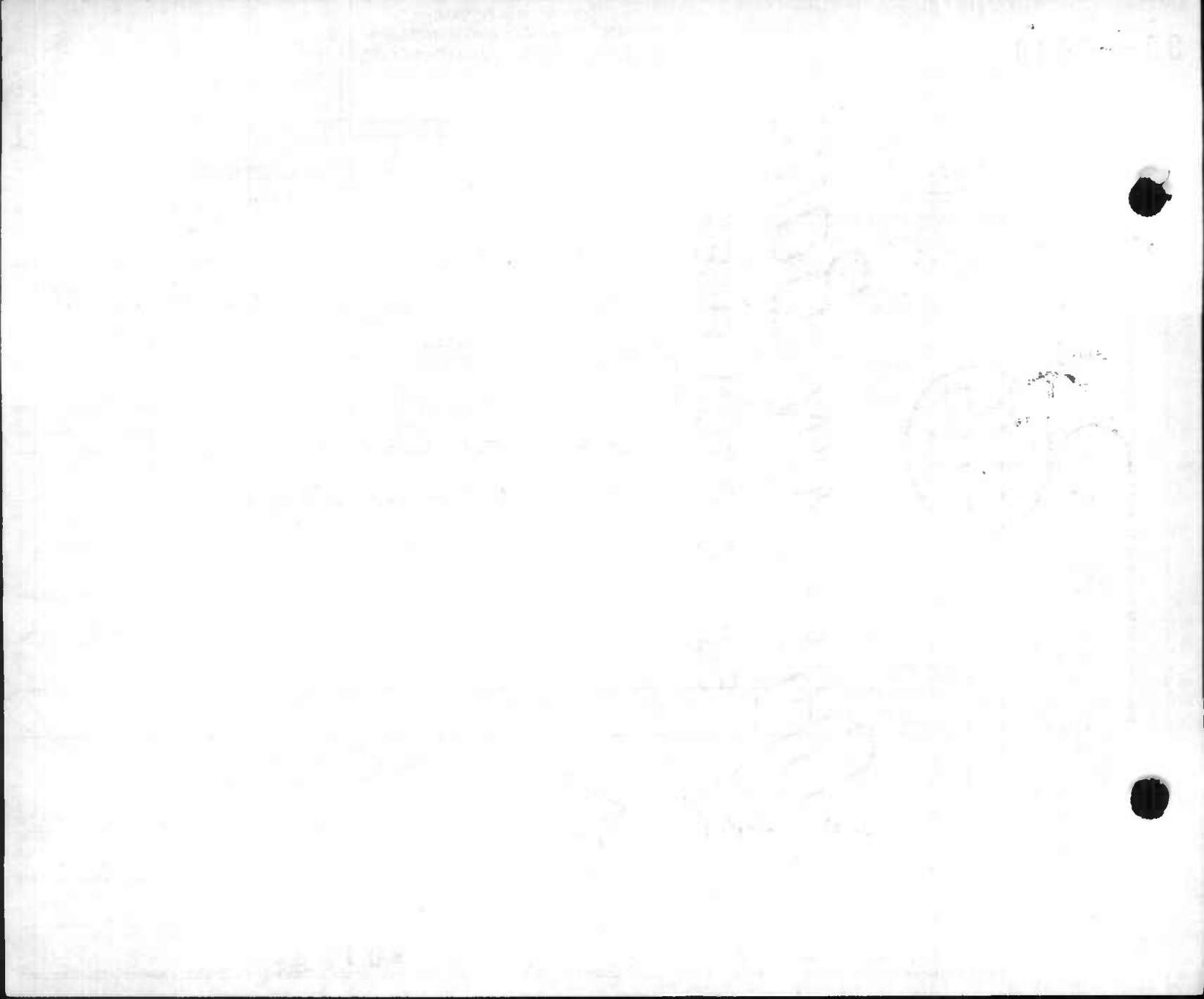
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/15/86	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR MAY 16 1986	

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked as "not at work," then the medical examiner must be notified at once.

BP _____
DHMH - 17
(VR A15 ME (5))



00-08513

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14924

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		HOUR	
Bertha S		Levin						12/24		12		24		1986		4:30 AM	
2. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	W	11/24/1917		77 YRS.		MONTHS		DAYS		12/24		12		24		1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Wisc.		USA		WIDOWED		DIVORCED		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
St. Louis		Holy Cross Hosp		Housewife		Own Hm											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Mont.		Cherrybrook		NO		2712 Blaine Dr.									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Isadore		Greenberg		Jenny		Levin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		213 46 9766		Jonathan Levin		1401 Cauthan Ct. Richmond											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Acute Myocardial Dis													
				Chronic Myocardial Dis													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2											
		P.M.		19													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
NOT WHILE AT WORK		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET													
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
EXAMINER'S NAME		ADDRESS															
Burial		May 27 1986		King David Mem'l Park		Falls Church, Virginia											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Ives-Pearson Funeral Homes		Falls Church, Va				MAY 28 1986		Julia Davidson-Rodriguez									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, WORKING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))



0-08658

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit this paper, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury for official investigation, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14925

REG. NO.

1- FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
1 DECEASED NAME (TYPE OR PRINT) FIRST MORTON J LAST LEVITAN			5 22 86			6:55 P.M.		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR APRIL 13, 1924	6 AGE (IN YEARS LAST BIRTHDAY) 62	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH SILVER SPRING	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES		12b KIND OF BUSINESS OR INDUSTRY REAL ESTATE			
13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN ROCKVILLE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 20852 12000 OLD GEORGETOWN ROAD				
14 FATHER'S NAME FIRST BARNUM A. MIDDLE LAST LEVITAN			15 MOTHER'S MAIDEN NAME FIRST RENA MIDDLE LAST DANNHEISER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN		16b SOCIAL SECURITY NO. WW 11 579-26-1841	17 INFORMANT ADDRESS LAURENCE LEVITAN, 6610 ROCKLEDGE DRIVE BETHESDA, MARYLAND					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure								
DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS DURING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 4/20, 19 86, to 5/22, 19 86, that (I) (we) last saw the deceased alive on 5/22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE OF PHYSICIAN [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/23/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD				22e ADDRESS 4701 Rockledge Rd Rockville, Md				
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 5/25/1986		23c NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS		23d LOCATION OLNEY, MONTGOMERY, MARYLAND		
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a DATE REC'D. BY REGISTRAR MAY 29 1986		25b REGISTRAR'S SIGNATURE [Signature]		

100-220

WASHINGTON, D.C.
JANUARY 1941

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT



00-09179

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH • 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jacob			2a. DATE OF DEATH MONTH DAY YEAR 5-30-1986			2b. HOUR 9:00 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 8 05		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant-Teacher		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Israel			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline (Unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 206-20-0761			17 INFORMANT Judith L. Walters			ADDRESS 13816 Flint Rock Road, Rockville, Md. 20853			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MAY 23 19 86 to MAY 30 19 86 , that (I) (we) lost sight of the deceased alive on MAY 30 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jerome J. Schnapp, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/31/1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome J. Schnapp, MD			22e. ADDRESS 11161 New Hampshire Avenue Silver Spring, MD 20904						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/1/1986		23c. NAME OF CEMETERY OR CREMATORY Haym Solomon Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frazer, Pennsylvania		
24. NAME OF FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR JUN 04 1986			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

232 CARROLL STREET, N. W., WASHINGTON, D. C.

⑤

1990

00-08917

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 14927

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Kung-Ti Li		05 31 86		11:22 PM	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Oriental		October 2, 1909		76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
China		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Shady Grove Adventist Hospital		Owner		Restaurant	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Unknown		Unknown		No		219-36-8471	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Kung-Mei Li Wife		CARDIO RESPIRATORY ARREST CORONARY ARTERY DISEASE		50 min.		5 years.	
Same as 13		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		Chronic Obstructive Pulmonary Disease; Cor Pulmonale		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/1/85, to 5/31/86, that (I) (we) lost saw the deceased alive on 5/31/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		Carl I. Schoenberger MD.		5/31/86		Carl I. Schoenberger	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		June 5, 1986		Gate of Heaven Cemetery		Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME	
Francis J. Collins Jr.		JUN 9 1986		John Collins Jr.		500 University Blvd., W. Silver Spring, Md.	

00-07502

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614928

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hsu Hsiu-Kuan LIN			2a. DATE OF DEATH MONTH DAY YEAR 5-22-86		2b. HOUR 12:35 A
1. SEX Female	4. RACE ORIENTAL	5. DATE OF BIRTH MONTH DAY YEAR 10 01 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHINA-TAIWAN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST SHUN - CHANG Hsu			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 491-68-1462		17. INFORMANT ADDRESS NANCY WEI (DAUGHTER) 13820 CASTLE BLVD. #203 SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF End stage Renal failure (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/6/86 , 19 86 , to 5/22 , 19 86 , that (I) (we) last saw the deceased alive on 5/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE GITA C. BAKSHI MD		DEGREE MD		22c. DATE SIGNED 5/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GITA C. BAKSHI MD		22e. ADDRESS 14820 Physicians La. Suite 243 Rockville Md 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY/22/86		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, PG. CO., MARYLAND		23e. DATE REC'D. BY REGISTRAR MAY 23 1986			
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		24b. ADDRESS SILVER SPRING, MD.			

00-02502

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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

00-07006

10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL PERMIT. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14929			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN G. LOFFT										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 13 19 86		2b. HOUR M M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 21, 1931		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 14 19 86		2d. HOUR 2A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada				7b. CITIZEN OF WHAT COUNTRY? Canada				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Willard Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Psychiatrist		12b. KIND OF BUSINESS OR INDUSTRY Self-emp.			
13a. STATE ---				13b. COUNTY MD				13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3048 Davenport St, NW/20008	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Hartley Lofft						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- Gordon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Vibeke T. Lofft, Same address as #13.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secobarbital Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5 13 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject ingested drug							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4701 Willard Ave Chevy Chase md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 5-14-86					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/19/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE 			

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00-06035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14930
REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		May 5, 1986		5:10aM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR	
Jan. 9, 1910		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		76	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY OR TOWN, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (IF MOST OF WORKING LIFE) Fiscal Administrator	
12b KIND OF BUSINESS OR INDUSTRY U.S. Government		13a STREET ADDRESS / ZIP CODE 4701 North Chelsea Lane		20814	
14 FATHER'S NAME FIRST MIDDLE LAST George Longpre		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura LeClerc		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b SOCIAL SECURITY NO. WW II		17 INFORMANT ADDRESS Catherine C. Longpre, same as #13		18 CAUSE OF DEATH	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 min.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u>		60 min.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>		years.

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from 5/4 to 5/5, 1986, that (1) (we) last saw the deceased alive on 5/4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		22b SIGNATURE Samuel D. Goldberg MD.		DEGREE		22c DATE SIGNED 5-5-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 11125 Rockville Pike, Rockville, Md 20852		22f DATE REC'D. BY REGISTRAR MAY 8 1986			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 8, 1986		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24 FUNERAL DIRECTOR Robert A. Pumphrey		25 DATE REC'D. BY REGISTRAR MAY 8 1986		25b REGISTRAR'S SIGNATURE Julia Davidson			
7557 Wisconsin Ave. Bethesda, MD 20814 PA							



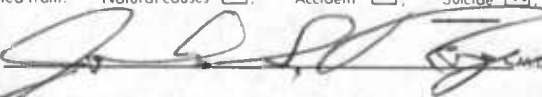
**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

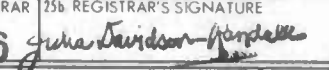
REG NO. **14931**

1. DECEASED NAME (TYPE OR PRINT) Bernard Merrill Longstreth										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED 5/20 1986		2b. HOUR P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH FEB. 27, 1913		6. AGE (IN YEARS) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 5/21 1986		7d. HOUR 12:30 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 12510 Feldon Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney				12b. BUSINESS OR INDUSTRY Law Practice	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12510 Feldon Street 20906					
14. FATHER'S NAME FIRST MIDDLE LAST Issac N Longstreth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delilah Booth									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 11 232-05-1625		17. INFORMANT Brother Baltimore, Maryland 21227 John Everett Longstreth 5616 Gateway Terr.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) hanging. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a: None											

19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR P.M. 5/20 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hung self.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Feldon Street, Silver Spring, Montgomery, Md.	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, Md.			
DATE SIGNED 5/21/86					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE 	
500 University Blvd. West Silver Spring, Md.							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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0-06345

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 9 3 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEON F LOOPER			2a. DATE OF DEATH MONTH DAY YEAR 5/10/86			2b. HOUR 1603			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Automotive Repair		12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 713 West Montgomery Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Looper					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nola Quisenberry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			16b. SOCIAL SECURITY NO. 218-22-0313		17. INFORMANT (Wife) ADDRESS Martha M. Looper, Ave., Rockville, Maryland				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis / Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Acute Leukemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ischemic heart disease / Sick Sinus Syndrome			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 , to Present 19 86 , that (I) (we) last saw the deceased alive on 5/10 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Douglas R. Shumaker				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS R. SHUMAKER, MD				22e. ADDRESS 615 W. MONTGOMERY AVE ROCKVILLE, MD 20850			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, MD				25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

70380-0

00-08144

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14933

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
HORACIO B. LOPEZ								5-24-86		19							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Hispanic	Aug. 22, 1946		39		YRS.				5-24-86		19				5:14P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Argentina		U.S.A.										Montgomery County		MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		Suburban Hospital		Laborer		Construction											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		25113 Hickory Ridge Lane		20879							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Angel Lopez		Mesades Salomes															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		577-02-5492		Lucy Julia Lopez (Wife)		Same as #13											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 5-26-86

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/29/86		Fort Lincoln Cemetery		Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				JUN 2 1986		John E. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - INHUMATION PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14934

1. DECEASED NAME (TYPE OR PRINT) KATHLEEN M. Lundborg		2a. DATE OF DEATH MONTH DAY YEAR MAY 5 1986		2b. HOUR 835 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 10, 1951		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH DAKOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE Adventist Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		13a. STATE MARYLAND	
13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DERWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN - LUNDBORG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOIS (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. NONE		17. INFORMANT LOIS KRUEGER		ADDRESS ONALASKA, WISCONSIN N5641 OAK HILL ADDITION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADULT RESPIRATORY DISTRESS SYNDROME DUE TO, OR AS A CONSEQUENCE OF (b) DIABETIC KETOACIDOSIS + HYPOTENSION DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from March 10, 1986, to May 5, 1986, that (I) (we) lost saw the deceased alive on 5/4 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Alan & Charles		DEGREE MD		22c. DATE SIGNED May 5, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN CHANALES		22e. ADDRESS 9410 OLD GEORGETOWN RD BETHESD		22f. MEDICAL STAFF ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY 10, 1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G. CO. MARYLAND		24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR MAY 16 1986	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. ADDRESS SILVER SPRING, MD.			

BP

2534. 25 625-410



00-06444

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 9 3 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Barbara Luykx		2a. DATE OF DEATH MONTH DAY YEAR May 1, 1986		2b. HOUR 3:16 P M	
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR Jan 5, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. XXX MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ----
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Montgomery Gaithersburg		13b. INSIDE CITY LIMITS? X YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 19310 Club House Road 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Louis T. McFadden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helene Westgate			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-46-9991	17. INFORMANT 19310 Club House Rd Gaithersburg, Md. 20879 Henrik M.C. Luykx			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRIC HAEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATION OF COLON-DIVERTICULITIS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) EMPHYSEMA.			
19a. DATE OF OPERATION 4-26-86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforation of colon. DIVERTICULITIS	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-21 , 19 86 , to 5-1 , 19 86 , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DR David Newsome	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-2-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR DAVID NEWSOME		22e. ADDRESS 3906 Bel PRE ROAD, WHEATON Md 20906	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation	23b. DATE May 3, 1986	23c. NAME OF CEMETERY OR CREMATORY Lee Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Sharon E. Leonard, St. Michaels Md		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE J. Michael...

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 9 3 6

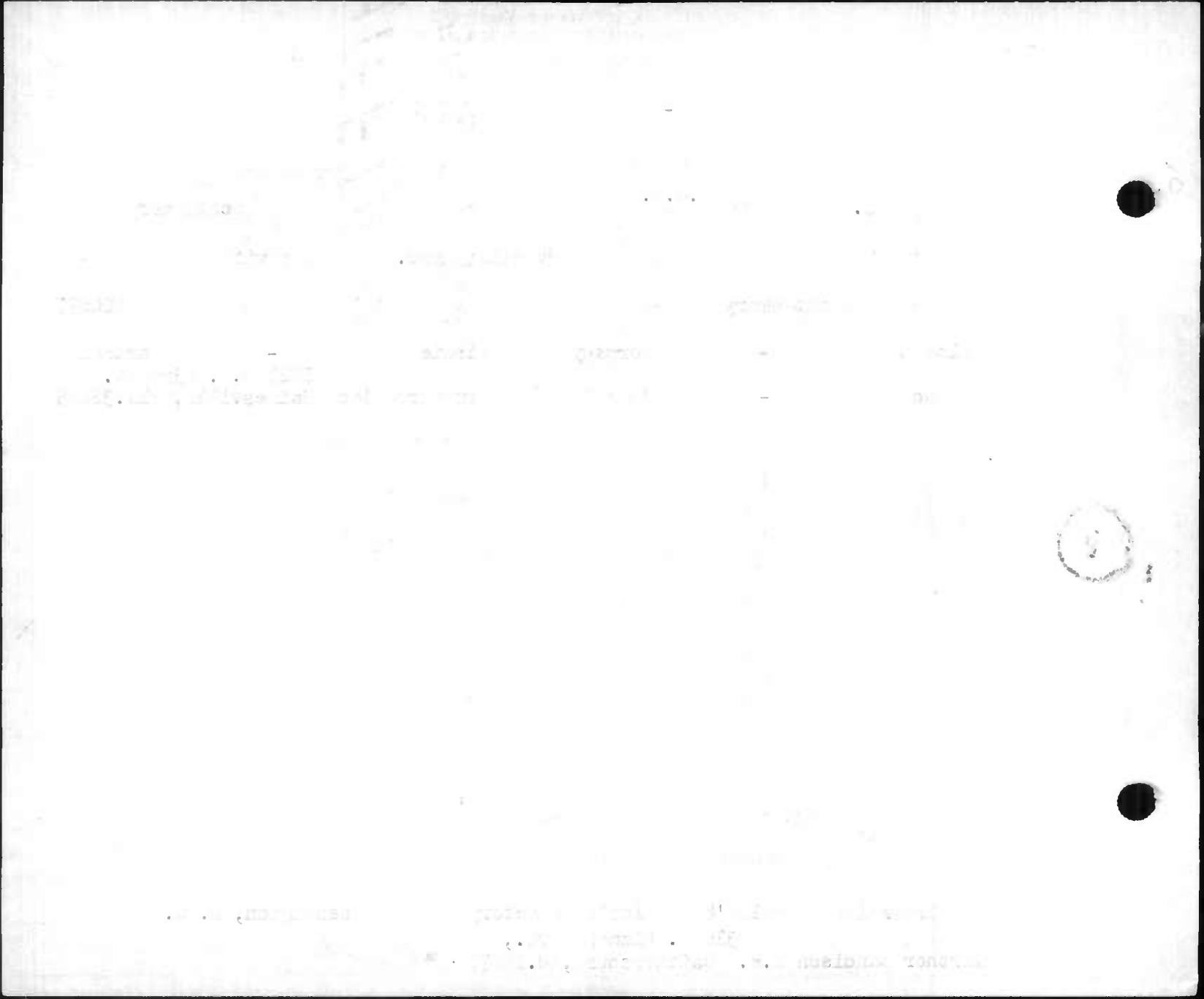
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLEN - MACDERMOD			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 10 86		2b. HOUR 0253 AM
3. SEX F	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 8 17 10	6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 10 86
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A. Montgomery		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
11. CITY OR TOWN OF DEATH Rockville		12b. KIND OF BUSINESS OR INDUSTRY -		13a. STATE MD.	
13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert - Hermamy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie - Hartman		17. INFORMANT ADDRESS 1221 N.W. 43rd St. Prudence Rice Gainesville, Fla. 32605	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 164-201391		17. INFORMANT ADDRESS 1221 N.W. 43rd St. Prudence Rice Gainesville, Fla. 32605	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE J. Michael Anchors		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER DATE SIGNED 5/10/86 MD 20877	
EXAMINER'S NAME (TYPE OR PRINT) J. MICHAEL ANCHORS		ADDRESS 15 E. DEER PARK, GAITHERSBURG			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/10/86		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN Washington, D. C.		23e. DATE REC'D. BY REGISTRAR MAY 15 1986		23f. REGISTRAR'S SIGNATURE John Sandison	
24. FUNERAL DIRECTOR Gartner Sandison 316 E. Diamond Ave., Gaithersburg, Md. 20877					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80



00-07145

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 9 3 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GABOR C MAPARAS			2a. DATE OF DEATH MONTH DAY YEAR 5-16-86		2b. HOUR 12³⁰ PM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1924		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 2 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Officer		12b. KIND OF BUSINESS OR INDUSTRY Government U.S.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11605 Deborah Drive/20854	
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel Madaras			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Csonka							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 195-18-5013		17. INFORMANT ADDRESS Anne E. Madaras, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metabolic acidosis								APPROXIMATE INTERVAL BETWEEN (a) AND (b) 2 wks		
DUE TO, OR AS A CONSEQUENCE OF (b) Uremia								6 wks		
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure								4 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Glomerulonephritis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 5/15/86 19 to 5/16/86 19 that (I) (we) last saw the deceased alive on 5/15/86 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated:										
22b. SIGNATURE Henry C. Scrivens				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/16/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRIVENS MD				22e. ADDRESS 5413 Cedar Lane Bethesda Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Funeral Homes 300 West Montgomery Ave. Rockville, MD PA		25a. DATE REC'D BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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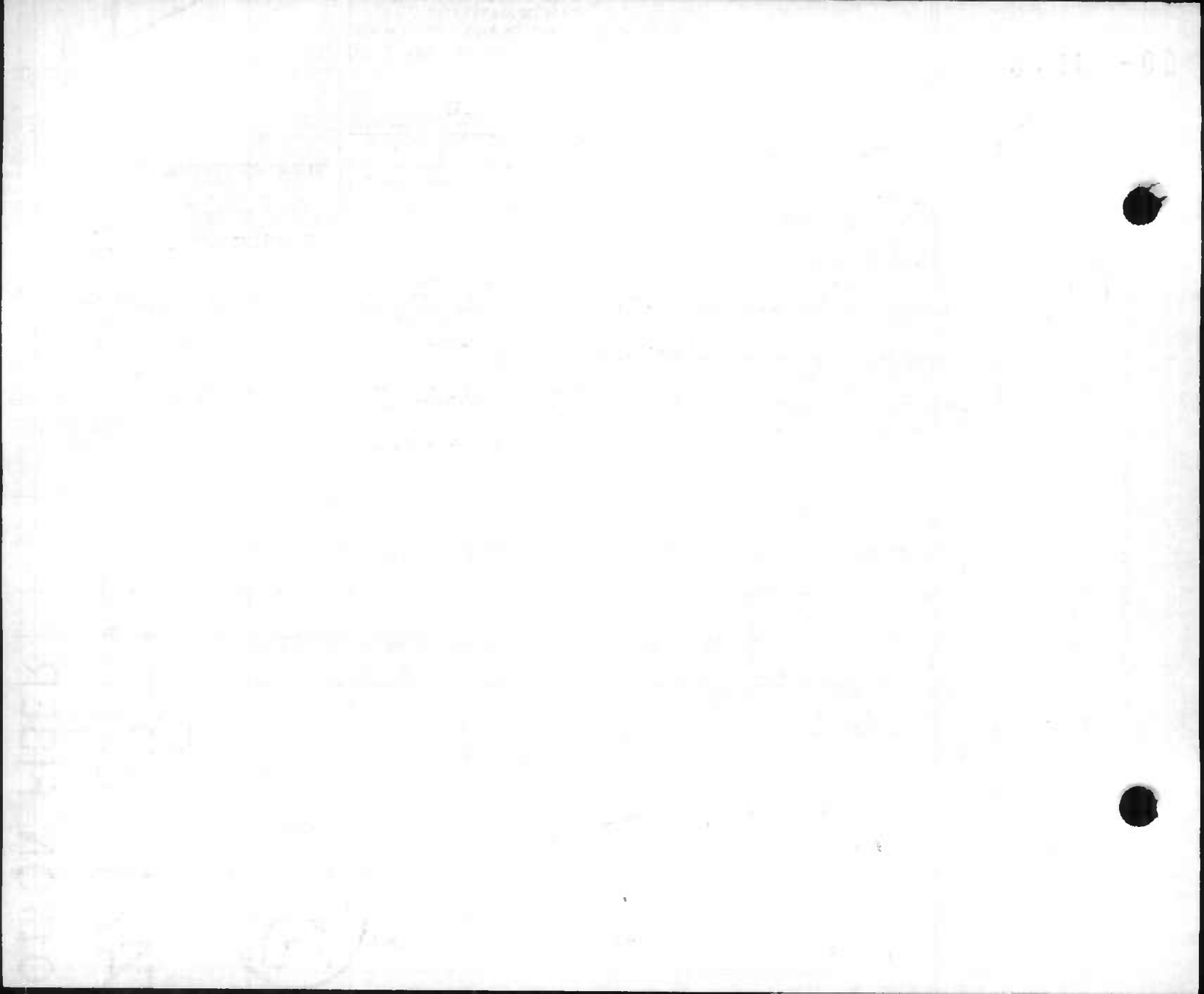


00-06328

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14938	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) BOHDAN MAKSYMJUK										2b. DATE EST. OF DEATH MATED <input checked="" type="checkbox"/> 5 7 1986	
2. SEX Male 3. RACE White 4. DATE OF BIRTH May 18, 1958 5. AGE (IN YEARS) 27										2c. DATE PRONOUNCED DEAD 5 8 1986	
6. IF UNDER 1 YR MONTHS DAYS HOURS MIN. 7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.										2d. HOUR 9:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey 7b. CITIZEN OF WHAT COUNTRY? USA										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										10. CITY OR TOWN OF DEATH Silver Spring	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) truck-10615 New Hampshire Ave.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TV Repairman	
12b. KIND OF BUSINESS INDUSTRIES Townsend Industries											
13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN S.S.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Stefan Maksymjuk										13e. STREET ADDRESS 709 Burnt Mills Court	
15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Halyna Zachwalynsky										13f. ADDRESS Same as 13E	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None										16b. SOCIAL SECURITY NO. 597 84 8768	
17. INFORMANT (NAME AND ADDRESS) Stefan Maksymjuk (Father)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Incised wound of forearm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-7- 19 86	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject cut self.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) truck	
21f. LOCATION (CITY OR TOWN, STREET) 10615 New Hampshire Ave.,										21g. LOCATION (CITY OR TOWN, STREET) Silver Spring	
21h. LOCATION (CITY OR TOWN, STREET) Montgomery, MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. TITLE (SPECIFY) Assistant										DATE SIGNED 5-9-86	
22c. EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										ADDRESS 111 Penn St., Balto., MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 5/14/86	
23c. NAME OF CEMETERY OR CREMATORY South Bound Brook Ukrainian Cemetery										23d. LOCATION (CITY OR TOWN, COUNTY, STATE) South Bound Brook, N.J.	
24. FUNERAL DIRECTOR (NAME) Hines/Rinaldi										25. DATE RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 13 1986	
24. ADDRESS 11800 New Hamp Ave. Silver Spring, Md.											



00-06364

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14939
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kailash Chandra Malhotra			2a. DATE OF DEATH MONTH DAY YEAR 05 08 86		2b. HOUR 12³⁰ PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 17, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India	7b. CITIZEN OF WHAT COUNTRY? India	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Printing
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Ijamsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ratan Chand Malhotra		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vidhya Rani			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 60 3695		17. INFORMANT ADDRESS Theresa J. Malhotra (wife) same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Upper Gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/8/86 , 19 86 , to 19 , that (I) (we) last saw the deceased alive on 5/8/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Shakir		DEGREE MD		22c. DATE SIGNED 5/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMLETH SHAKIR MD		22e. ADDRESS 6001 Lux Lane Rockville MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN Alexandria		STATE Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey			25a. DATE REC'D. BY REGISTRAR MAY 13 1986		
ADDRESS 300 W. Montgomery Ave., Rockville, Maryland			25b. REGISTRAR'S SIGNATURE Gina...		

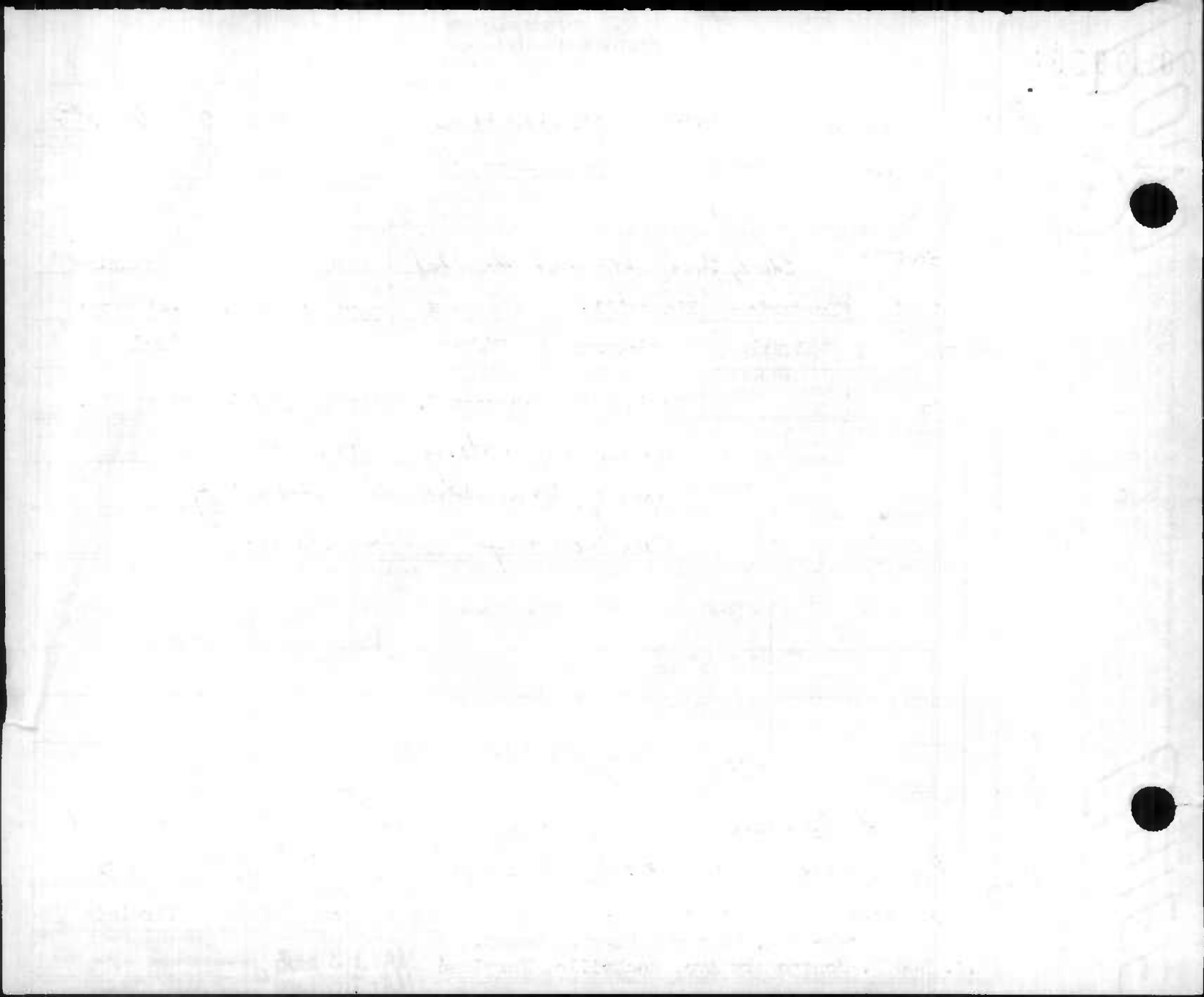
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-00155

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Mildred Mangan			2a. DATE OF DEATH MONTH DAY YEAR May 22 1986		2b. HOUR 10:00am
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 21 st 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10037 Dallas Avenue 20901
14. FATHER'S NAME FIRST MIDDLE LAST William Keister		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Whelan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. 220-46-2931		17. INFORMANT Daughter Doris M. Broderick 10002 Brunette Avenue 20901		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Thyroid carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>none</u>			
19a. DATE OF OPERATION 1983	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CB - of trachea	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>7/26</u> , 19 <u>86</u> , to <u>5</u> , 19 <u>88</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED 5/22/88
22b. SIGNATURE <u>Edward T. O'Donnell</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward T. O'Donnell, M.D.	22e. ADDRESS 10313 Georgia Ave. Silver Spring, MD 20903	

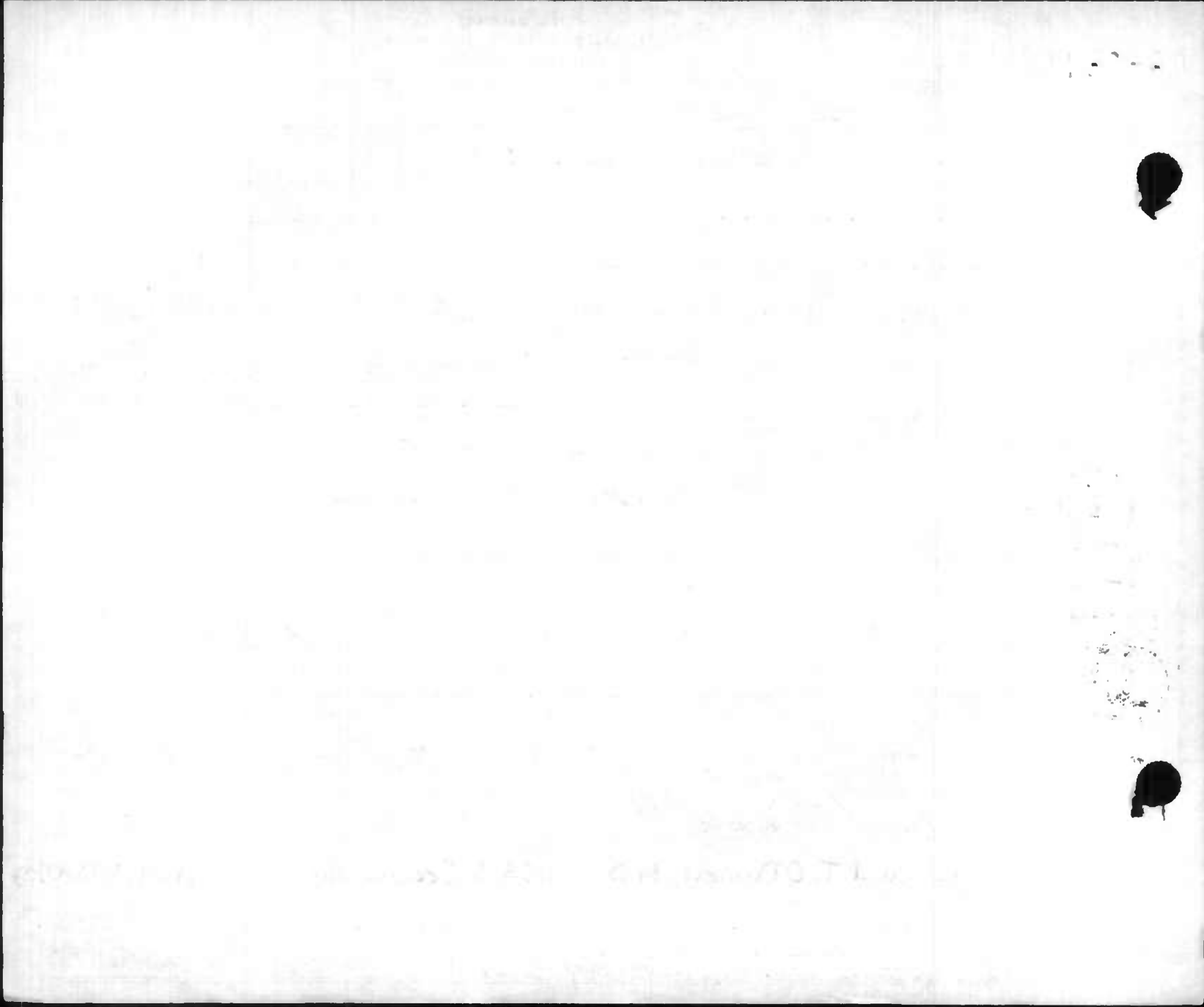
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 24, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUN 2 1986 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove any postmarks. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 is any injury, or other traumatic event, the medical examiner must be notified at once.



00-07338

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GREGORY MARK MARDEN			2a. DATE OF DEATH MONTH DAY YEAR MAY 17, 1986		2b. HOUR 10:35A_M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 2, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER PROGRAMMER		12b. KIND OF BUSINESS OR INDUSTRY COMPUTER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WASH. DC		13b. COUNTY NONE		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN MARDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIA RIGICK		13e. STREET ADDRESS / ZIP CODE 2400 VIRGINIA AVE, C1101, NW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 561-27-1972		17. INFORMANT MR. LAWRENCE REGER ADDRESS (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumocystis pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Acquired immune deficiency syndrome						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 3 weeks 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 12 , 19 86 , to MAY 17 , 19 86 , that (I) (we) lost saw the deceased alive on MAY 17 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Paul L. Rogers MD				DEGREE MD		22c. DATE SIGNED 5/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul L. Rogers				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA MD 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-19-1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



Handwritten signature or initials.

0-07147

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14942

1. DECEASED NAME (TYPE OR PRINT) Charles Poole Marsden			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1986		2b. HOUR 10:14pM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 31 01		6. AGE (IN YEARS LAST BIRTHDAY) 85	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR National Bureau of Standards
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles P. Marsden, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Nock		13e. STREET ADDRESS / ZIP CODE 403 Russell Ave. 20760	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 136 10 2181		17. INFORMANT Son LeRoy W. Marsden	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ruptured abdominal aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION 5/16/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured abd. aortic aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/14 19 86, to 5/16 19 86, that (I) (we) last saw the deceased alive on 5/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert L. Fox MD		DEGREE MD		22c. DATE SIGNED 5/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Fox MD		22e. ADDRESS 18111 Prince Philip Dr., Olney, Md. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 18, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN Alexandria		COUNTY Virginia		STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes, P.A.		25a. DATE REC'D. BY REGISTRAR MAY 21 1986			
300 West Montgomery Ave. Rockville, Maryland		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7-11-1-0



00-08648

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 9 4 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pauline P. Martin			2a. DATE OF DEATH MONTH DAY YEAR May 24, 1986			2b. HOUR 3:45 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 16, 1905		6. AGE (IN YEARS (LAST BIRTHDAY)) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Silver Spring				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John Postell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not available		13e. STREET ADDRESS / ZIP CODE 9400 Garwood Street / 20901					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 168-16-7760		17. INFORMANT ADDRESS Pauline Boyd/9400 Garwood St. Silverspring Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION
NO

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from April 20, 1986, to present, 1986, that (I) (we) last saw the deceased alive on May 7, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal23b. DATE
May 24 198623c. NAME OF CEMETERY OR CREMATORY
Eden Cemetery23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Collingdale, Pennsylvania

24. FUNERAL DIRECTOR
NAME
McGuire Funeral Service

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

7400 Georgia Ave. N.W. Washington, D.C. 20012

JUN 1 1986 John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-06312

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard T. Mathews			2a. DATE OF DEATH MONTH DAY YEAR 5 09 86			2b. HOUR 1800M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 6 18		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Old Fort N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD.			
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Dept. Gen. Serv.	
13a. STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 520 Crittenden St. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur W Mathews			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annabelle Lytle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 578-16-4352		17. INFORMANT Mrs. Carol D. Powell/daughter/1264 Jackson St., N.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiomyopathy & Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a <u>Chronic Renal Failure, Diabetes, Hypertension</u>									
19a. DATE OF OPERATION 2-21-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gongrene Left Foot</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-19-86</u> to <u>5-09-86</u> , that (I) (we) last saw the deceased alive on <u>5-09-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Hazel M. Tape, M.D.</u>				DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-10-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAZEL M. TAPE				22e. ADDRESS 1011 North Capitol St. N.E.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-86		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.			
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C. 20017				25a. DATE REC'D. BY REGISTRAR MAY 13 1986					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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00-06937

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Carol J Matson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-13-86</i>		2b. HOUR <i>4:30 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>November 1, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>71</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co. MD.</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>National Park Service</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Fred C. Johnson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Viola Figgins</i>		16. STREET ADDRESS / ZIP CODE <i>9509 East Bexhill Drive 20895</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577 60 0853</i>		17. INFORMANT ADDRESS <i>Walter D. Matson Husband same as 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRAIN Stem infarct, Right Cerebellum</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cerebral emboli</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Infarct</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>Renal failure - Diabetes Mellitus, Pneumonia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ANATOMY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 20, 1986</i> to <i>May 13, 1986</i> that (I) (we) last saw the deceased alive on <i>May 13, 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Roland Imperial MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5-14-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Roland Imperial MD</i>		22e. ADDRESS <i>4977 Battery Lane Bethesda MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>May 14, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A.</i>				25. DATE REC'D BY REGISTRAR <i>MAY 19 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	
25a. ADDRESS <i>7557 Wisconsin Ave. Bethesda, Maryland 20814</i>							

MEDICAL CERTIFICATION

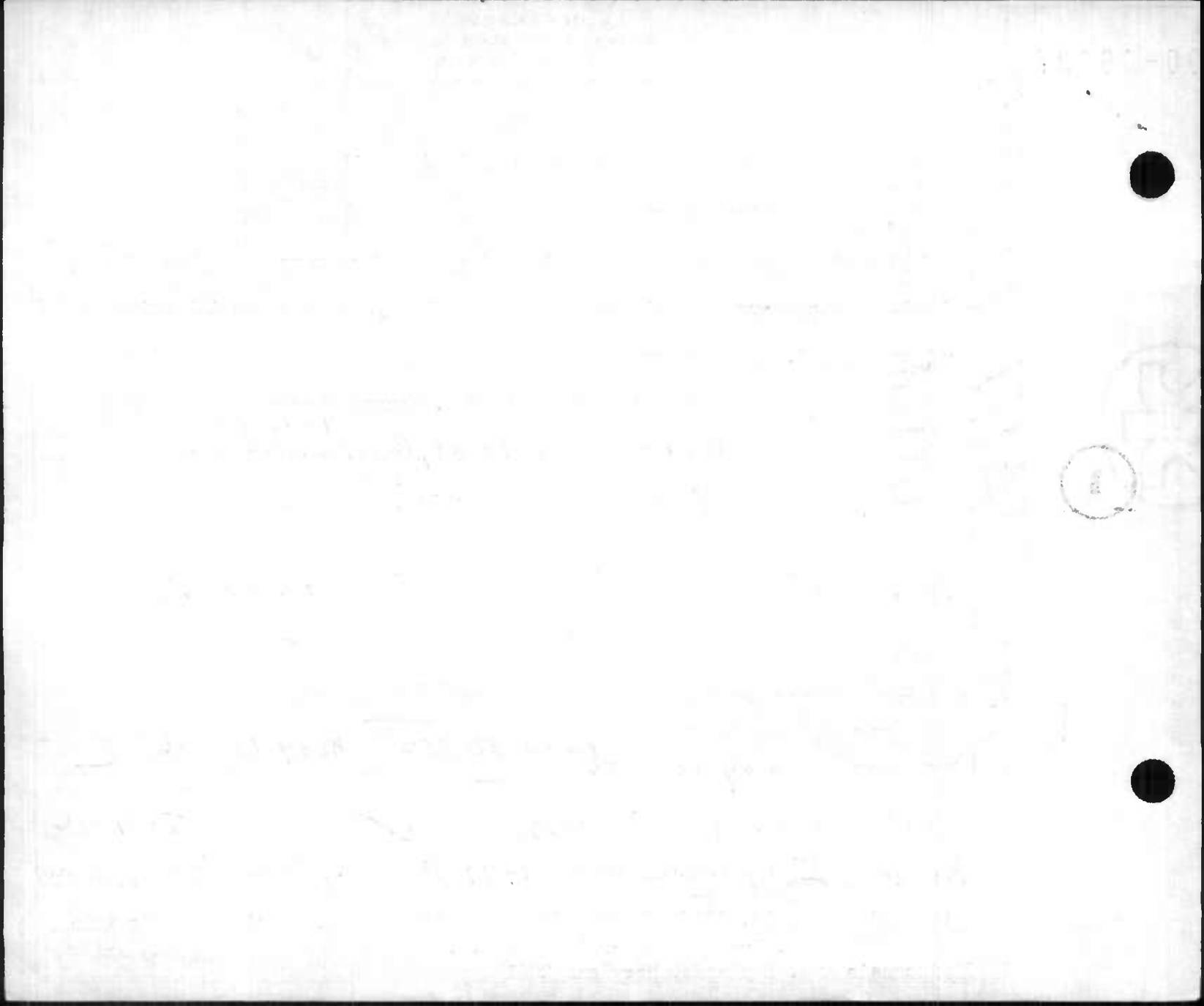
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-07652

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 9 4 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WAYNE ANTHONY MCCURDY			2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1986		2b. HOUR P 5:21
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 17 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	
14. FATHER'S NAME FIRST MIDDLE LAST OKIE MCCURDY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE MUEHLEMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1941-1961	17. INFORMANT ADDRESS ELIZABETH MCCURDY, 8305 LORING DRIVE, BETHESDA, MD 20817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) _____ (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 13 , 19 86 , to MAY 17 , 19 86 , that (I) (we) last saw the deceased alive on MAY 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. H. Edmunds</i>				22c. DATE SIGNED 20 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. EDMUNDS, LCDR, MC, USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremated		23b. DATE May 20, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		
24. FUNERAL DIRECTOR DeVol Funeral Home, Inc. 2222 Wisc. Ave., NW., Wash., DC 20007					
25a. DATE REC'D. BY REGISTRAR MAY 26 1986				25b. REGISTRAR'S SIGNATURE <i>J. H. Edmunds</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

1. The first of the great principles of the Republican Party is the principle of individual liberty. This principle is the foundation of all our rights and liberties, and it is the duty of every citizen to protect and defend it.

2. The second principle is the principle of justice. Justice is the foundation of all our rights and liberties, and it is the duty of every citizen to protect and defend it.

3. The third principle is the principle of equality. Equality is the foundation of all our rights and liberties, and it is the duty of every citizen to protect and defend it.

4. The fourth principle is the principle of economy. Economy is the foundation of all our rights and liberties, and it is the duty of every citizen to protect and defend it.

5. The fifth principle is the principle of patriotism. Patriotism is the foundation of all our rights and liberties, and it is the duty of every citizen to protect and defend it.

00-05189

Film G615 item 13e

1- FOR STATE REGISTRAR 5/9/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) Corda Mae McDonald			2a. DATE OF DEATH MONTH DAY YEAR Apr. 24, 1986		2b. HOUR 9:10 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 30 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10112 Parkwood Dr.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		
14. FATHER'S NAME FIRST MIDDLE LAST Volney Cearnal		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vola Meador		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 490-10-5500		17. HUSBAND ADDRESS Mr. Lewin S. McDonald		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Several Years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: As #13						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/15 19 86 to April 24 19 86 , that (I) was last saw the deceased alive on 4/15 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) was did not view the body after death.						
22b. SIGNATURE James W. Egan M.D.				22c. DATE SIGNED 4/25/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Egan, M.D.				22e. ADDRESS 5413 Cedar LA. Beth., MD 20814		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/86		23c. NAME OF CEMETERY OR CREMATORY Dudenville Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Dudenville, Mo.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				
25a. DATE REC'D. BY REGISTRAR APR 30 1986				25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Approved by Dr. Mayle (ME)

• 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 8

CONFIDENTIAL

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0-07405

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614948
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude McGowan			2a. DATE OF DEATH MONTH DAY YEAR May 19 1986		2b. HOUR 9:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH April 15 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2010 Grace Church Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 2010 Grace Church Road 20910		
14. FATHER'S NAME FIRST MIDDLE LAST Asa E. Houk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Newton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Lillian M. McGowan-daughter-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Mitral valve insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Jan 3 , 19 89 , to April 28 , 19 86 , that (2) (we) last saw the deceased alive on April 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald B. Landman MD		DEGREE M.D.		22c. DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald B. Landman, MD		22e. ADDRESS 9440 Penna. Ave., Upper Marlboro, Md. 20772			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Crementation	23b. DATE May 20, 1986	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Medical examiner's report, if any, should be filed with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury or other traumatic cause, medical examiner's report must be filed at once.

BP _____



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 REG. NO. 1 4 9 4 9

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles H. Harold McIntyre			2a. DATE OF DEATH MONTH DAY YEAR May 9, 1986		2b. HOUR 5:02 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1905		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Mining				
13a. STATE W. Va.		13b. COUNTY Marion		13c. CITY OR TOWN Idamay		
14. FATHER'S NAME FIRST MIDDLE LAST James McIntyre		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Myrtle Coon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-09-7202		17. INFORMANT ADDRESS 28121 Rudale Dr. Clarksburg, Md. 20871		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC PULMONARY ARTERY DUE TO, OR AS A CONSEQUENCE OF (c) MYO CARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS 2 HOURS 4 HOURS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.) MYO CARDIUM - RENAL INSUFFICIENCY - CHRONIC PULMONARY DISEASE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/9 , 19 86 , to 5/9 , 19 86 , that (I) (we) lost saw the deceased alive on 5/9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 5/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCORIO K. H.D.		22e. ADDRESS 13-15 E DEER PARK DR GAITHERSBURG MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Shinnston Masonic		
23d. LOCATION CITY OR TOWN COUNTY STATE Shinnston, Harrison, W. Va.						
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md. 20872				25a. DATE REC'D. BY REGISTRAR MAY 12 1986		
				25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

Operation, Report

Date

Time

May 17, 1965

BC

. Va.

USA

Postmaster General,

Rockville

Inter

. C.

Station

Library

Patrol R. 20376

James

Postmaster

Inc

Article

Good

to

534-0-7875

Lock R. Postmaster

20181 Article R.

Journal, Vol. 2, 1961

May 17, 1965

Article

Office of the Postmaster General, Washington, D.C.

Washington, D.C.

00-06606

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY D McINTYRE			2a. DATE OF DEATH MONTH DAY YEAR 5-8-86			2b. HOUR 5:20 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor Care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Clerical		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3903 Weller Road 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A Rubright			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Littlewood			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 168-16-5140			17. INFORMANT ADDRESS George McIntyre Husband Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from April 27 1986 to May 8 1986 , that (I) (we) last saw the deceased alive on May 8 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Boris Rabkin			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-8-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS RABKIN, MD			22e. ADDRESS 1819 Univ Blvd LEX							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 13, 1986		23c. NAME OF CEMETERY OR CREMATORY Leverington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia Pennsylvania			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.						25a. DATE REC'D BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE James Harrison Anderson		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please transmit this and page 4 to the funeral home.

IMPORTANT: If item 21 is marked or item 28 checked, any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 5 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen H metzger				2a. DATE OF DEATH MONTH DAY YEAR 5/27/86		2b. HOUR 4 P.M.	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-26-06		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR	
12b. KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE		13a. STREET ADDRESS / ZIP CODE 627 SLIGO AVE. 20910					
13b. STATE MARYLAND		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD - HARRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE - BIERBOWER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-24-9908		17. INFORMANT ADDRESS RUTH A. MILLER (DAUGHTER) 4007 74TH PLACE HYATTSVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic and Valvular Heart Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (the hospital) attended the deceased from 5/26 19 86 to 5/27 19 86 , that (i) (the) lost saw the deceased alive on 5/26 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did not) view the body after death.							
22b. SIGNATURE Frank N. Gravino				DEGREE MD		22c. DATE SIGNED 5/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank N. Gravino				22e. ADDRESS 10313 Georgia Ave, Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY 28, 1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, PG. CO., MARYLAND	
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR JUN 2 - 1986	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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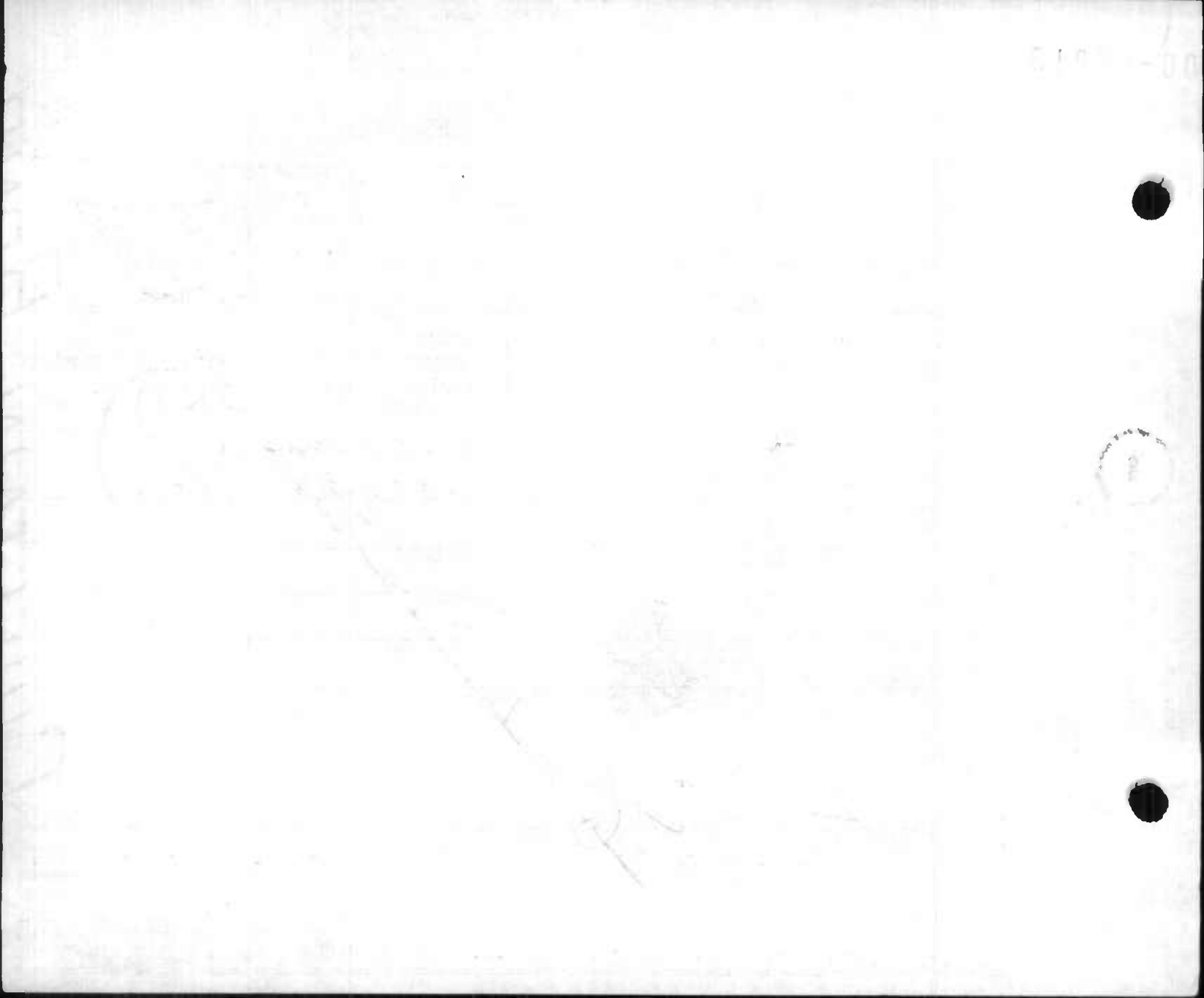
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14952

1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cecil George Miller						2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 7, 1986					
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Nov 8, 1940	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 7, 1986					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica		7b. CITIZEN OF WHAT COUNTRY? Jamaica		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Analyst		12b. KIND OF BUSINESS OR INDUSTRY University			
13a. STATE MD		13b. COUNTY Montgomery		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20994 Foxthorn Rd					
14. FATHER'S NAME FIRST MIDDLE LAST Cecil George Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Ingram							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-66-1949		17. INFORMANT 2049 Featherwood Street Silver Spring, Md. Beverley Downie							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers M.D.				TITLE (SPECIFY) MEDICAL EXAMINER				DATE SIGNED May 7, 1986			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS 1919 Seminary Rd. Silver Spring, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE (SPECIFY) May 10 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Wheaton, Maryland			
24. FUNERAL DIRECTOR NAME McGuire Funeral Service				ADDRESS 7400 Georgia Ave D.C.				25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



00-06605

DIVISION OF VITAL RECORDS, 201 WESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4953	
1. DECEASED NAME (TYPE OR PRINT) Charles Luther Miller										2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 10 1986	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Oct 13 23 62		6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.		7. IF UNDER 4 YR. MONTHS DAYS HOURS MIN.		7b. HOUR 8:15 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH S. L. Spg.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hosp. Cross Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baggage Handler			12b. KIND OF BUSINESS OR INDUSTRY Pan Am		
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN S. L. Spg.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John N. Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel D. Fisher			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. INFORMANT Brother James S. Miller		
16a. SOCIAL SECURITY NO. 578-22-0346			17a. ADDRESS 1967 New Holland Pike Lancaster, Pa. 17601			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dist. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M.D.			TITLE (SPECIFY) Medical Examiner			DATE SIGNED MAY 11 1986					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Rd. Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 14, 1986			23c. NAME OF CEMETERY OR CREMATORY ST JOHN'S U.M. CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE PARADISE LANCASTER PA.		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS JR.			25a. DATE REC'D. BY REGISTRAR MAY 15 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall					
\$00 UNIVERSITY BLVD., W. SILVER SPRING, MD.											

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WASHINGTON, D.C.

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STATE
REGISTRAR

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24 FUNERAL DIRECTOR

GENERAL DIRECTOR
FRANCIS H. BARBER

LAYTONSVILLE, MD. 20879

25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
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MAY 12 1985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP.



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00-08653

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

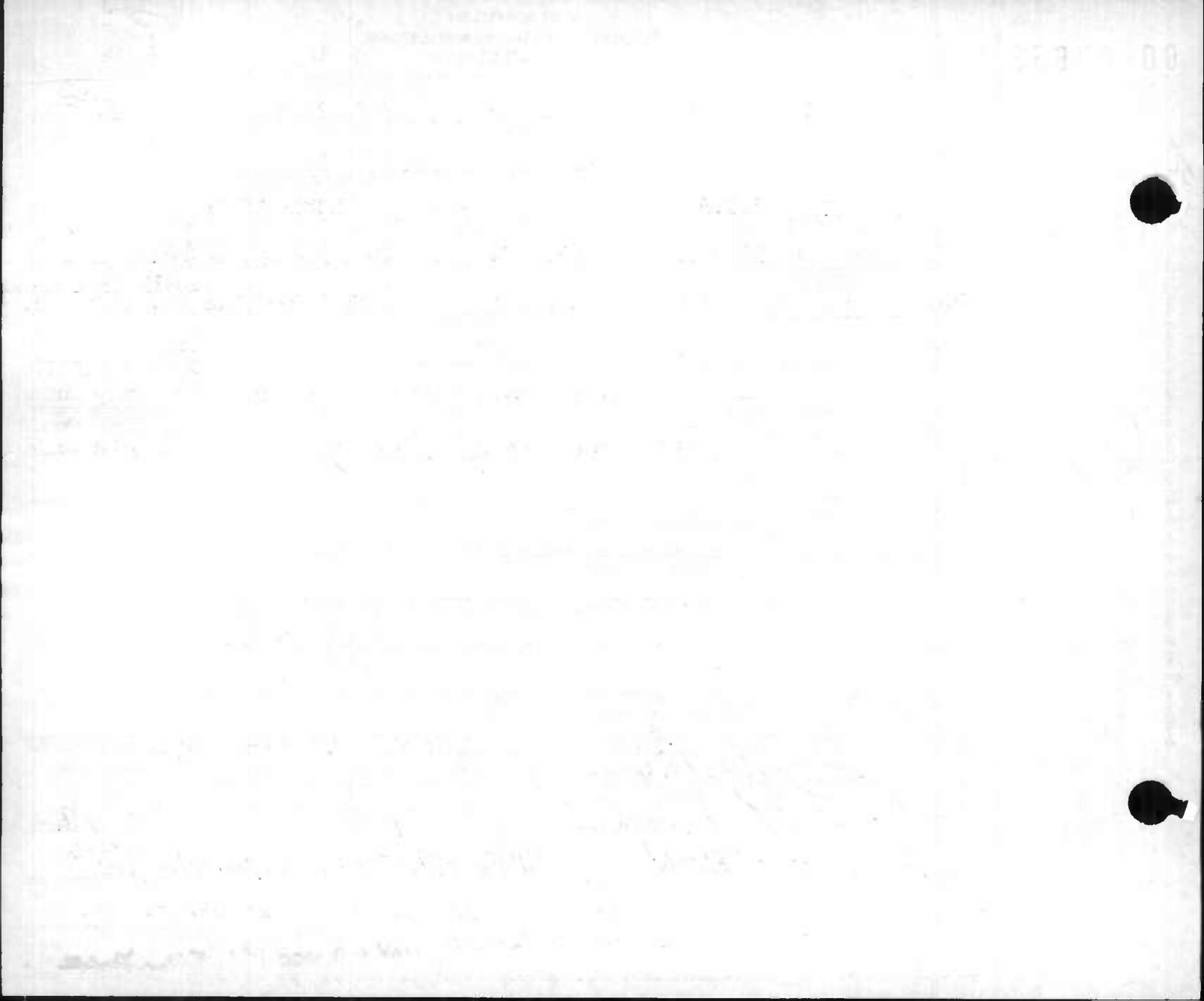
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate, pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALD J. MILLER					2a. DATE OF DEATH MONTH DAY YEAR MAY 25 1986					2b. HOUR 3:20 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR February 20, 1930			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH CHEVY CHASE MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3207 PAULINE DR. CC. MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Developer; Miller			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTG. 13c. CITY OR TOWN CHEVY CHASE					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3207 PAULINE DR. C.C. MD. 20815 / Companies				
14. FATHER'S NAME FIRST MIDDLE LAST Morris Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Bregman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-34-9125		17. INFORMANT Judith Miller; 3207 Pauline Drive; Chevy Chase,			ADDRESS Maryland 20815				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>1985</u> to <u>5-25-</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/25/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lewis H Biben</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/25/86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS H BIBEN					22e. ADDRESS 1145-19TH ST NW Washington DC 20036						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/27/86		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden			23d. LOCATION (CITY OR TOWN) COUNTY STATE Falls Church; Fairfax; Va.				
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE <u>Richard Randall</u>				



00-068441

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

14956

1. DECEASED NAME (TYPE OR PRINT) CARMEN LENA MITCHELL			2a. DATE OF DEATH MONTH DAY YEAR MAY 14 1986			2b. HOUR A M 12:10			
1. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 8 1935		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST INDIES		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSES' AIDE		12b. KIND OF BUSINESS OR INDUSTRY HEALTH CARE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NEW YORK		13b. COUNTY QUEENS		13c. CITY OR TOWN QUEENS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 55-30 99th STREET 11374	
14. FATHER'S NAME FIRST MIDDLE LAST TIMOTHY DALE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RITINELLA BRAMWELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 081-40- 1339		17. INFORMANT Barbara Gilbert, 638 MAGENTA ST., BRONX, NY 10467					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF SEPSIS Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) MYCOSIS FUNGOIDES (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 29 , 19 86 , to MAY 14 , 19 86 , that (I) (we) lost saw the deceased alive on MAY 14 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. Pierdinock</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 14 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. PIERDINOCK, LCDR, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hastings, New York			
24. FUNERAL DIRECTOR NAME ADDRESS McCall's Bronxwood Funeral Home 4025 Bronxwood Avenue, Bronx, NY 10466				25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-07286

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

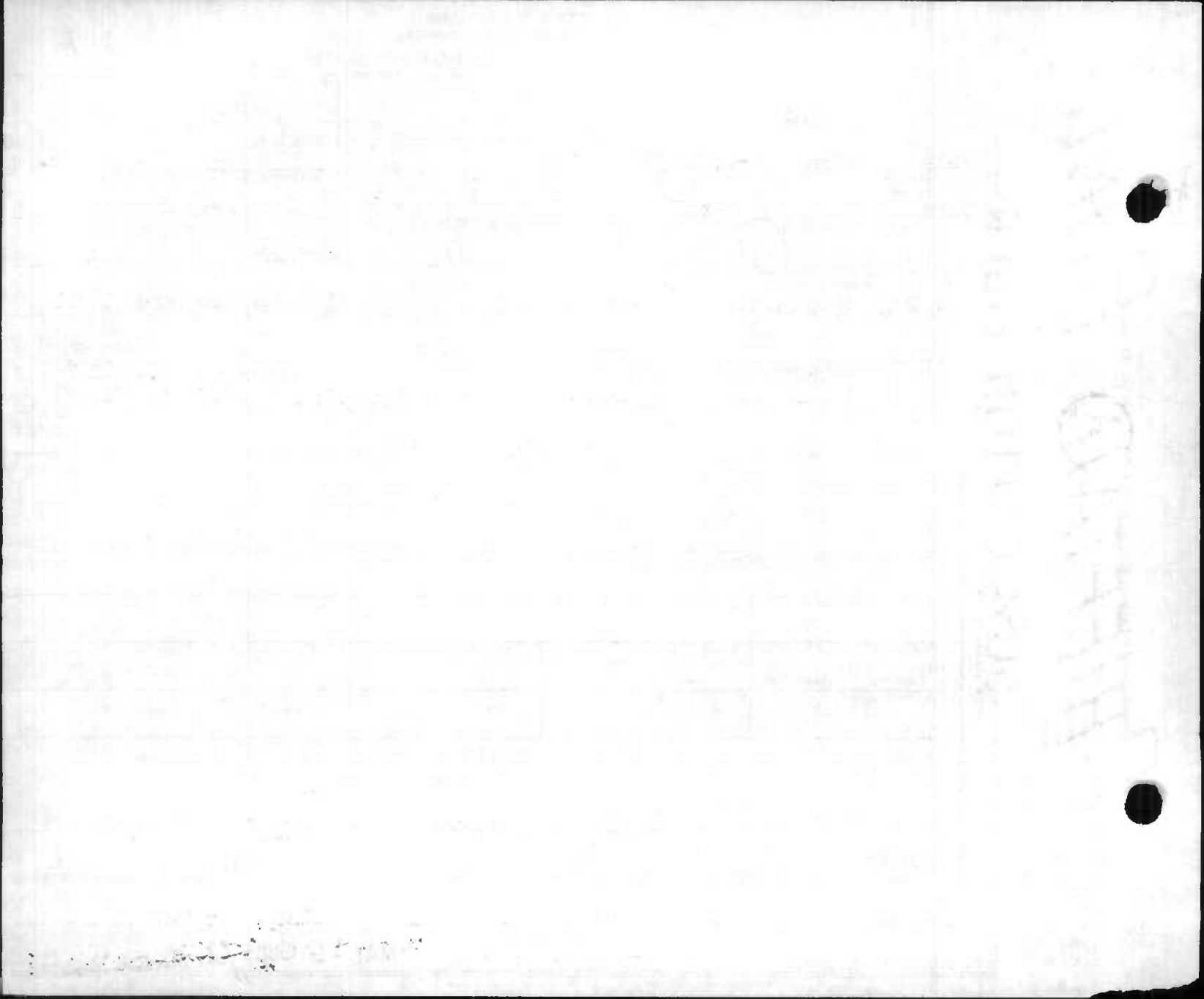
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14957

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		DATE ESTIMATED		MONTH DAY YEAR	
FIRST MIDDLE LAST		XX 5-13 1986		M	
Ebrahim Moaadel					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	Sept. 7, 1910	75 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Iran	Iran	WIDOWED	DIVORCED	Montgomery County, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	6111 Montrose Road, Apt. 1019	Merchant	Furs		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
		Maryland	Montgomery	Rockville	YES X NO
		13e. STREET ADDRESS			
		6111 Montrose Road 20852			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Moussa Lavy		Dina Denarosh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		218-06-7208AI		Bethesda, Md., 20817	
		Moussa Moaadel; 10240 Arizona Circle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Acute Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Coronary Arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES XX NO
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy X Inspection Inquiry and in my opinion					
Natural causes X Accident Suicide Homicide Undetermined manner					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant		5-15-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	May 16, 1986	Judean Mem. Gardens		Olney, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels; 1170 Rockville Pike		MAY 19 1986		Julia Davidson	



00-06980

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS AGNES MOORE			2a. DATE OF DEATH MONTH DAY YEAR 5 18 86		2b. HOUR 3:00 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 3 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD	13b. CITY OR TOWN Capitol Hights	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS & ZIP CODE 1540 Ritchie-Marlboro Rd., 20743		
14. FATHER'S NAME FIRST MIDDLE LAST James Garner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217366149		17. INFORMANT James M. Moore-Capitol Hights, Md. 20743	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiovascular Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/18/86
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Operation Pneumonia					5/86
DUE TO, OR AS A CONSEQUENCE OF (c) CHF					5/86
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dehydration, ASCVD, Senile Dermatitis, COPD					
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) NO	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/20/86 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 5/20/86 , 19____, to 5/18/86 , 19____, that (1) saw the deceased alive on 5/17/86 , and that in my opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.					
22b. SIGNATURE G B Patrick MD		DEGREE M.D.		22c. DATE SIGNED 5/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick MD		22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/21/86	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton (Pr. Geo's) Md.	
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Md. 20772			25a. DATE REC'D. BY REGISTRY MAY 19 1986		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give it to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

22



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614959
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES WIXSON MOORE			2a. DATE OF DEATH MONTH DAY YEAR MAY 28 1986		2b. HOUR 10:17 ^A
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 29 1921	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VIRGINIA	13b. COUNTY FAIRFAX	13c. CITY OR TOWN ANNANDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4017 WHISPERING LANE 22003	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK GEORGE WIXSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MCCALLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1943-1944	17. INFORMANT ADDRESS ALVAN N. MOORE, 4017 WHISPERING LANE, ANNANDALE, VA 22003			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **METASTATIC OVARIAN CANCER**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

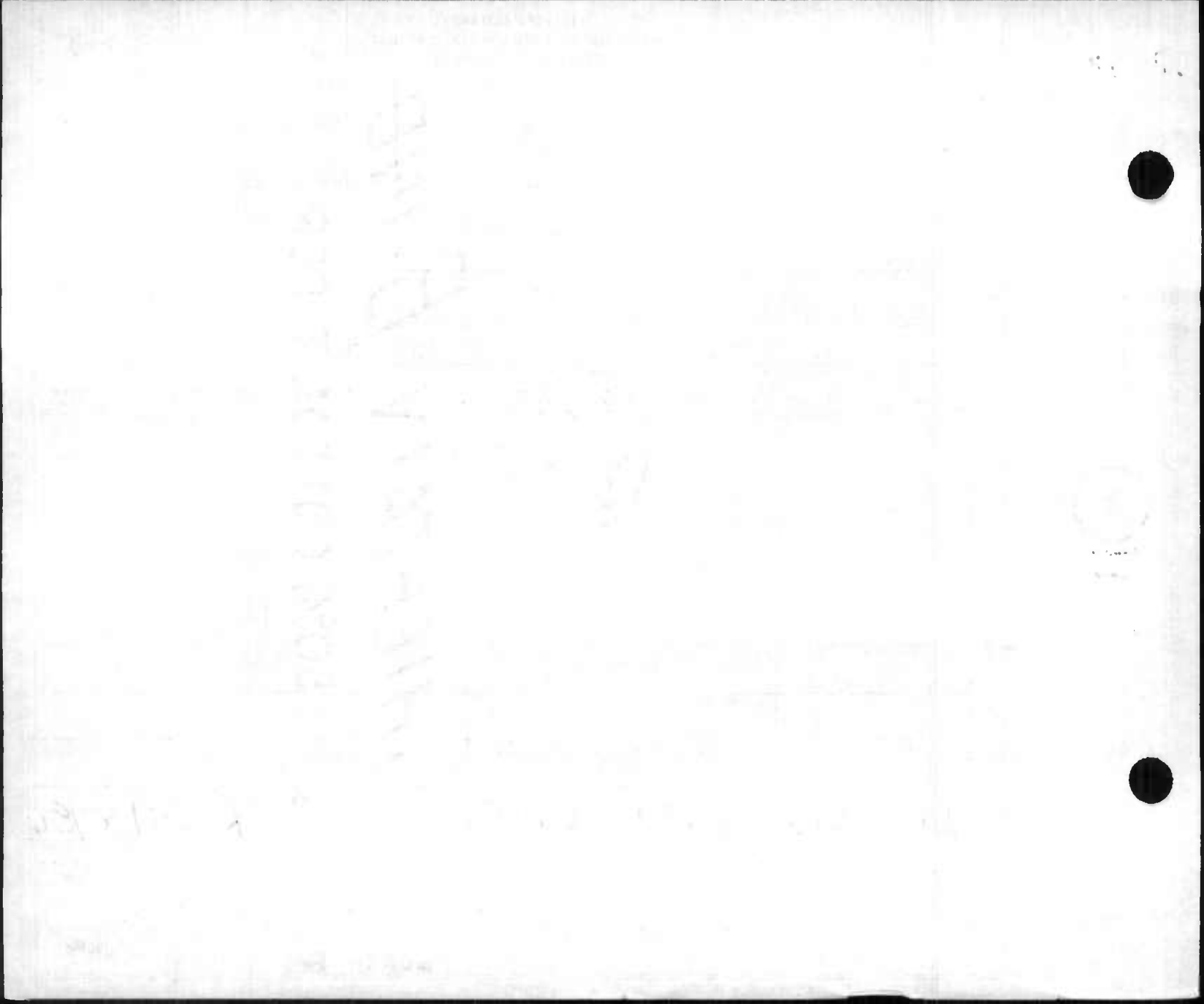
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 13 , 19 86 , to MAY 28 , 19 86 , that (I) (we) last saw the deceased alive on MAY 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE MC Thabault	DEGREE MD	22c. DATE SIGNED 05/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. THABAULT, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 2, 1986	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va. 22201		25a. DATE REC'D. BY REGISTRAR JUN 2 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



00-07918

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roland E. Moore			2a. DATE OF DEATH MONTH DAY YEAR May May 23. 1986		2b. HOUR 11:30 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 21 1917			
7a. BIRTHPLACE (STATE OR FOREIGN) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11202 Mitscher Street		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
12a. USUAL OCCUPATION (TYPED WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY US Govt.				
13a. STATE Md			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winnie Curtin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-10-4237		17. INFORMANT ADDRESS Elizabeth Holloman same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Gallbladder (6-85) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 10 19 86, to May 23 19 86, that (I) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE Richard W. Holt, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-23-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Holt, M.D.				22e. ADDRESS 3800 Reservoir Rd., N.W. Wash., D.C. 20007			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood Prince George's County, Md.	
24. FUNERAL DIRECTOR NAME Donald F. Borgwardt				4400 Powder Mill Rd. Beltville Md 20705		25a. REC'D BY 25b. REGISTERAR'S SIGNATURE MAY 28 1986	

MEDICAL CERTIFICATION

BP

RECEIVED
JAN 10 1964
U.S. AIR FORCE

01050-0
JAN 10 1964

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then submit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8614961		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Ray W.		Moreland		Moreland				5/26/86		3:15 AM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		WHITE		11 10 18		67					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington D.C.		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (1. OF WORK FOR MEDICAL LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Wheaton		University Conv. & N. Home		Parent Research		Self Employed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MD		Mont.		Silver Spring		YES		13807 Castle Blvd. 20904			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John H. Moreland		Ella Spicer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
yes		WW11		Christine M. Moreland-wife-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Adenocarcinoma of the</u>											
(c) <u>Brain, Bones, and Liver</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>1984</u> , 19 <u>84</u> , to <u>5-25-86</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>5-20-86</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated.											
23a. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				23c. DATE SIGNED			
<u>Charles L. Franklin Jr</u>		MD						5/26/86			
23b. PHYSICIAN'S NAME (TYPE OR PRINT)		23d. ADDRESS									
Charles L. Franklin Jr		11120 New Hampshire Ave Silver Spring 20904									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		May 28, 1986		George Washington		Adelphi Prince Georges Md.					
24 FUNERAL DIRECTOR NAME		11800 N.H. Ave.,		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hines/Rinaldi Funeral Home		Silver Spring, Md.		MAY 28 1986							



00-06880

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER F. MORELAND			2a. DATE OF DEATH MONTH DAY YEAR 5-10-86		2b. HOUR 8:25 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY SEALTEST DAIRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL E. MORELAND		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOUISE BRANZELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-03-8829		17. INFORMANT ADDRESS DAUGHTER - BETTY M. CROSBY - SAME AS #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy, Arter.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD, Pleurisy, Vascular Disease, Angioma</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-19-86</u> to <u>5-19-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Douglas R. Shumaker MD</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/10/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS R. SHUMAKER MD		22e. ADDRESS 615 W. MONTGOMERY AVE ROCKVILLE, MD 20856	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 13, 1986	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MD.
24. FUNERAL DIRECTOR NAME <u>James W. [unclear]</u>		25a. DATE REC'D. BY REGISTRAR MAY 14 1986	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical examiner will retain the original certificate and the medical examiner's report at the time of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will retain the original certificate and the medical examiner's report at the time of death.

1

00-06806

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 1 4 9 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Carolyn Morgan			2a. DATE OF DEATH MONTH DAY YEAR May 14, 1986		2b. HOUR P 12:30
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher/Pennsylvania		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Plesant -Cook Britt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Humphries			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 199-32-4837		17. INFORMANT ADDRESS Bernice C. Morgan same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Atherosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/11/86
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 5/11/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/11/86, 1986, to 5/14/86, 1986, that (I) (we) last saw the deceased alive on 5/14/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lodmell		DEGREE MD		22c. DATE SIGNED 5/14/86	
22d. ADDRESS 18111 Prince Philip Drive, Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/18/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Smithfield, Pennsylvania					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR MAY 16 1986			
25b. REGISTRAR'S SIGNATURE [Signature]					

Cleared by Dr. John S. Rogers 5/14/86

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be kept by the funeral director for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified before signing.

BP

NAME	LAST, FIRST, MIDDLE	DATE OF BIRTH	PLACE OF BIRTH	EDUCATION	EMPLOYMENT	RESIDENCE	STATUS
1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32
33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48
49	50	51	52	53	54	55	56
57	58	59	60	61	62	63	64
65	66	67	68	69	70	71	72
73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88
89	90	91	92	93	94	95	96
97	98	99	100	101	102	103	104
105	106	107	108	109	110	111	112
113	114	115	116	117	118	119	120
121	122	123	124	125	126	127	128
129	130	131	132	133	134	135	136
137	138	139	140	141	142	143	144
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153	154	155	156	157	158	159	160
161	162	163	164	165	166	167	168
169	170	171	172	173	174	175	176
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217	218	219	220	221	222	223	224
225	226	227	228	229	230	231	232
233	234	235	236	237	238	239	240
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249	250	251	252	253	254	255	256
257	258	259	260	261	262	263	264
265	266	267	268	269	270	271	272
273	274	275	276	277	278	279	280
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289	290	291	292	293	294	295	296
297	298	299	300	301	302	303	304
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425	426	427	428	429	430	431	432
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449	450	451	452	453	454	455	456
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465	466	467	468	469	470	471	472
473	474	475	476	477	478	479	480
481	482	483	484	485	486	487	488
489	490	491	492	493	494	495	496
497	498	499	500	501	502	503	504
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513	514	515	516	517	518	519	520
521	522	523	524	525	526	527	528
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545	546	547	548	549	550	551	552
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561	562	563	564	565	566	567	568
569	570	571	572	573	574	575	576
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585	586	587	588	589	590	591	592
593	594	595	596	597	598	599	600
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649	650	651	652	653	654	655	656
657	658	659	660	661	662	663	664
665	666	667	668	669	670	671	672
673	674	675	676	677	678	679	680
681	682	683	684	685	686	687	688
689	690	691	692	693	694	695	696
697	698	699	700	701	702	703	704
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713	714	715	716	717	718	719	720
721	722	723	724	725	726	727	728
729	730	731	732	733	734	735	736
737	738	739	740	741	742	743	744
745	746	747	748	749	750	751	752
753	754	755	756	757	758	759	760
761	762	763	764	765	766	767	768
769	770	771	772	773	774	775	776
777	778	779	780	781	782	783	784
785	786	787	788	789	790	791	792
793	794	795	796	797	798	799	800
801	802	803	804	805	806	807	808
809	810	811	812	813	814	815	816
817	818	819	820	821	822	823	824
825	826	827	828	829	830	831	832
833	834	835	836	837	838	839	840
841	842	843	844	845	846	847	848
849	850	851	852	853	854	855	856
857	858	859	860	861	862	863	864
865	866	867	868	869	870	871	872
873	874	875	876	877	878	879	880
881	882	883	884	885	886	887	888
889	890	891	892	893	894	895	896
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905	906	907	908	909	910	911	912
913	914	915	916	917	918	919	920
921	922	923	924	925	926	927	928
929	930	931	932	933	934	935	936
937	938	939	940	941	942	943	944
945	946	947	948	949	950	951	952
953	954	955	956	957	958	959	960
961	962	963	964	965	966	967	968
969	970	971	972	973	974	975	976
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985	986	987	988	989	990	991	992
993	994	995	996	997	998	999	1000

100-100000



00-07332

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHMORGAN, HELEN
1919 DR. LIBRE, EUGENE
ADM 826 677 4916 1478
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Grace Helen Morgan			2. DATE OF DEATH MONTH DAY YEAR 5-16-86		2b. HOUR 8:30 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 19, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Procurement Specialist		12b. KIND OF BUSINESS OR INDUSTRY Health & Human Ser.
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3105 Adderley Court 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Silas Strouse		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 148-09-7674	17. INFORMANT Son Dennis Woolaver		ADDRESS 14808 Clavel Street Rockville, Md. 20853	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYCLOGENOUS LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 y/2x					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-16-86</u> to <u>5-16-86</u> , that (I) (we) lost <u>above</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE <u>Richard H. Pollen</u>		DEGREE MD		22c. DATE SIGNED 5-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Pollen		22e. ADDRESS 10400 Connecticut Ave KENNESWOTON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 20, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE <u>James Davidson Hendall</u>	
500 University Blvd., W. Silver Spring, Md.					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-05816

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transport permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 9 6 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Thomas C Moropoulos						2a. DATE OF DEATH MONTH 5 DAY 3 YEAR 86				2b. HOUR 2116 M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH 8 DAY 19 YEAR 31		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		7. UNDER 72 HRS. HOURS 0 MIN. 0			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
12. CITY OR TOWN OF DEATH Rockville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) musician		15. KIND OF BUSINESS OR INDUSTRY Self. employed					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Olney						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17700 King William Ct 20832					
14. FATHER'S NAME FIRST George MIDDLE Moropoulos LAST Moropoulos				15. MOTHER'S MAIDEN NAME FIRST Zoe MIDDLE Manganas LAST Manganas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Sarah B. Moropoulos-wife-(same as 13e)		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain metastases DUE TO, OR AS A CONSEQUENCE OF (b) Melanoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Adrenal metastasis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo 3 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Adrenal metastasis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from May 3, 1986 , to May 3, 1986 , that (I) (we) last saw the deceased alive on May 3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Peter Sherer MD				DEGREE MD				22c. DATE SIGNED May 4, 1986					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD				22e. ADDRESS 3947 Ferrara Dr. Wheaton Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, DC COUNTY STATE							
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

00-06342

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

BLAIR L. MULLICAN, JR.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

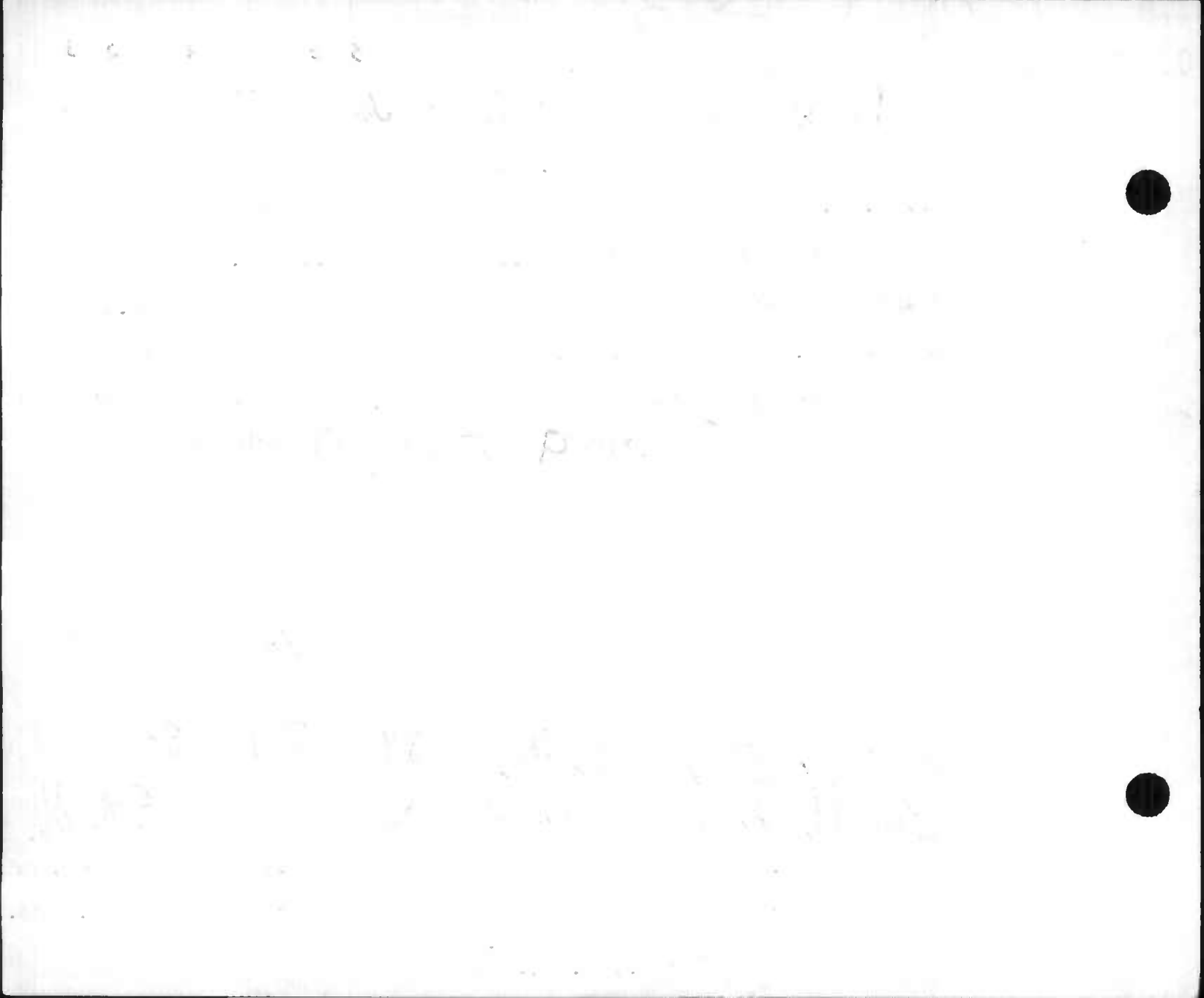
8 6

REG. NO.

1 4 9 6 6

1. DECEASED NAME (TYPE OR PRINT) Blair L. Mullican Jr.		2a. DATE OF DEATH MONTH DAY YEAR 5-10-86		2b. HOUR 1 A. M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1933	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10807 Ten Brook Dr., 20901	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec., Eng.	12b. KIND OF BUSINESS OR INDUSTRY GSA		
13a. STATE Maryland		13b. COUNTY Mont-Silver Spring	13c. CITY OR TOWN 10807 Ten Brook Dr., 20901	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Blair L. Mullican, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean 217-28-8436		17. INFORMANT ADDRESS Patricia A. Mullican-Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8-6 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 5-9 86	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10301 Georgia Ave., Silver Spring, Md.	
22a. I certify that (I) (this hospital) attended the deceased from 8-6 19 84 to 5-9 86 , that (I) (we) last observed (I) (we) (last) (observed) the body after death.					
22b. SIGNATURE Carroll D. Mahoney		22c. DEGREE M.D.		22d. DATE SIGNED 5-10-86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Carroll D. Mahoney		22f. ADDRESS 10301 Georgia Ave., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAY 13 1986			
24. FUNERAL DIRECTOR Takoma Funeral Home-		24a. ADDRESS 254 Carroll St. NW Wash., D. C. 20012		24b. DATE REC'D. BY REGISTRAR 24c. REGISTRAR'S SIGNATURE MAY 13 1986	

BP



00-06366

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14967

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN L. MURRAY		2a. DATE OF DEATH MONTH DAY YEAR 5 9 86		2b. HOUR 250	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Va.		13b. COUNTY	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Irving LeBar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Mae Unobtainable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 178 07 9880		17. INFORMANT (Asst. Adm. of M. & E.S. Home) Mollie Powell- 6000 N.H. Ave. NE Wash. DC.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerotic Heart Disease with Atrial arrhythmias</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>December 5/8/86</u> 19 <u>1985</u> to <u>5/9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/8/86</u> 19 <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Norton Elson</u>		DEGREE		22c. DATE SIGNED <u>5/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NORTON ELSON</u>		22e. ADDRESS <u>6525 Belcrest Rd Hyattsville MD 20782</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-13-1986		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <u>MAY 13 1986</u> <u>Jenna Davidson-Henderson</u>			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>MAY 13 1986</u> <u>Jenna Davidson-Henderson</u>			

00-0782

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14968
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIA MYKOLAIENKO			2a. DATE OF DEATH MONTH DAY YEAR MAY 26 1986			2b. HOUR 9:35 P.M.			
1. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? Permanent resident		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland			13b. COUNTY Prince Georges Mt. Rainier		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS?		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Skarzynski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria (unobtainable)			13e. STREET ADDRESS / ZIP CODE 3204 Bunker Hill Road 20712			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS 20904 Ostap Zynjuk-nephew-12523 Montclair Dr. S.S.Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GLIOBLASTOMA OF BRAIN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4 MONTHS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>CONGESTIVE HEART FAILURE - PNEUMONIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1986</u> , to <u>MAY 26 1986</u> , that (I/we) last saw the deceased alive on <u>MAY 26 1986</u> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/27/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LUIS BERTOLILLA MD</u>				22e. ADDRESS <u>5480 Wisconsin Ave - Chevy Chase Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPRINT) Burial		23b. DATE May 29, 1986		23c. NAME OF CEMETERY OR CREMATORY Ukrainian Orthodox		23d. LOCATION CITY OR TOWN COUNTY STATE South Bound Brook N.J.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md.		11800 N.H. Ave., ADDRESS		25a. DATE REC'D BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 701 W. WRESTON ST., BALTIMORE, MARYLAND 21201

1 2 3 4 5

00-05995

Item: 18a thru 22a Fill in 6/25/86
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14969

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY Auldridge NEAL			2a. DATE KNOWN OF DEATH ESTIMATED 5-4-86 19 M		2b. HOUR M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1958	6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13203 Foxhall Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Insurance
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 19808 Wheelwright Drive 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Thomas Auldridge		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST June Bisel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 215 72 2208		17. INFORMANT Husband David L. Neal		9330 Gorman Road #15 Laurel, Md. 20707	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotism</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>Est. 5/3/86</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Self injected</u>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>House (outside)</u>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>13203 Foxhall Dr. Silver Sp. Mont. Co. Md</u>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <u>Margarita A. Korell</u> EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5-5-86

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 8, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR MAY 8 1986	25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH VITAL RECORDS. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

07/84
25MBP 139
DHMH - 17
(VR A15 ME (5))

2009 OCT 10 11:01 AM

WINTER



(1)

00-05985

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 9 7 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARLA JEAN NELLES		2a. DATE OF DEATH MONTH DAY YEAR MAY 4 1986		2b. HOUR 9:10 P^M	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 27 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE		12b. KIND OF BUSINESS OR INDUSTRY HEALTH CARE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA		13b. COUNTY FAIRFAX	13c. CITY OR TOWN MCLEAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CARL NELLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEAN GUNN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 099-24-0203		17. INFORMANT ADDRESS JEAN E. REIS, 8340 GREENSBORO DRIVE, APT 322	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **MCLEAN, VA 22102**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 16, 1986 to MAY 4, 1986 , that (I) (we) lost saw the deceased alive on MAY 4, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J.P. Mehegan</i> DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 MAY 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MEHEGAN, LT, MC, USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 6, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME <i>Money & King</i> ADDRESS Vienna, W. Maple Ave. Virginia			25. DATE REC'D. BY REGISTRAR MAY 8 1986 25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 2 should be retained by the funeral director. Page 2 should be retained by the funeral director. Page 2 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)



WASH. STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 7 1

REG. NO.

1- FOR
STATE REGISTRAR Phyllis G. Newton

1. DECEASED NAME (TYPE OR PRINT) PHYLLIS G. NEWTON			2a. DATE OF DEATH MONTH DAY YEAR 5-31-86		2b. HOUR 9:50 AM	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 05 16		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Ret. & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Sectry.		12b. KIND OF BUSINESS OR INDUSTRY World Bank	
13a. STATE N/A	13b. COUNTY N/A	13c. CITY OR TOWN Wash., DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2201 L St. NW 20037		
14. FATHER'S NAME FIRST MIDDLE LAST Walter R. M. Newton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Ann Alger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 230-34-6291		17. INFORMANT ADDRESS Meade C. Patrick 2500 Q St. NW Wash., DC 20007		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH week			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Arteriosclerosis generalized years			
DUE TO, OR AS A CONSEQUENCE OF			(c) Cardiovascular accident WEEKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 66 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the hospital) attended the deceased from Jan 19 66 to MAY 31 19 86 , that (I) (we) last saw the deceased alive on MAY 29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.						
22a. SIGNATURE Arnold A. Lear MD		DEGREE		22c. DATE SIGNED 5/31/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arnold A. Lear, MD		22e. ADDRESS 2201 L St. NW Wash., DC 20037				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/3/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Alex., VA						
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		ADDRESS 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR JUN 04 1986		
		25b. REGISTRAR'S SIGNATURE [Signature]				

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00-06220

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14972
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Kim Lau Ng</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-6-86</i>		2b. HOUR <i>6⁵⁵ am</i>				
3. SEX <i>FEMALE</i>		4. RACE <i>ORIENTAL</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6-13-97</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>CHINA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>CHINA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOME MAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>MARYLAND</i>			13b. CITY OR TOWN <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>	
17. SOCIAL SECURITY NO. <i>220-88-1758</i>			18. INFORMANT <i>SON</i> ADDRESS <i>SILVER SPRING, KIN CHOI 601 SILVER SPRING AVENUE MD. 20910</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Chronic Renal Failure - Acute Exacerbation. Severe Dehydration. Anorexia</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> 19 <i>86</i> to <i>5/8</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5/8</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Antonio G. Uy</i>			DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. UY</i>			22e. ADDRESS <i>831 Univ. Blvd S. # 25 S.S. Md 20903</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>MAY 9, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BRENTWOOD PRINCE GEO. MARYLAND</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 12 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Marjorie R. Riddle</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-07317

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4973

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																													
1. DECEASED NAME (TYPE OR PRINT) Daisy Nichols										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 19 86										2b. HOUR 4 A M																													
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR June 24, 1914 71 YRS.			6. AGE (IN YEARS LAST BIRTHDAY) 71			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 19 86			2d. HOUR 11 A M																															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia					7b. CITIZEN OF WHAT COUNTRY? United States					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD																																		
10. CITY OR TOWN OF DEATH Rockville					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 402 Park Road.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker					12b. KIND OF BUSINESS OR INDUSTRY own home																													
13a. STATE Maryland										13b. COUNTY Montgomery					13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 402 Park Road. 20850																								
14. FATHER'S NAME FIRST MIDDLE LAST Antonia Izze										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Bell Izze										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 214 32 9476										17. INFORMANT ADDRESS Myrtle Prystaj 2903 Kensington Blvd. Kensington, Maryland 20895									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)																									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																	
ACTUAL SIGNATURE John Tauber										TITLE (SPECIFY) Deputy										DATE SIGNED May 19, 1986																													
EXAMINER'S NAME (TYPE OR PRINT) John Tauber M.D.										ADDRESS 8218 Wisconsin Ave. Bethesda, MD																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE May 22, 1986					23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park					23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland																													
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey										25a. DATE REC'D. BY REGISTRAR MAY 22 1986										25b. REGISTRAR'S SIGNATURE [Signature]																													
PA 300 W. Montgomery Av., Rockville, Md.																																																	

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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PAID 10-10-10
10-10-10



00-07316

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove categories 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14974
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUKE J. Nolan Sr.			2a. DATE OF DEATH MONTH DAY YEAR 5-21-86			2b. HOUR 5 ¹⁰ A.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care-Wheaton				12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Property Manager		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3927 Washington Street 20895	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Nolan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Mooney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 057-18-7965		17. INFORMANT ADDRESS Alice W. Nolan, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INCREASED INTRACRANIAL PRESSURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAIN TUMOR - PRIMARY</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MINS.</u> <u>3 DAYS</u> <u>15 MONTHS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>None</u>										
19a. DATE OF OPERATION <u>MARCH 1985</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1985</u> to <u>May 21 1986</u> , that (I) <u>we</u> lost saw the deceased alive on <u>May 19 1986</u> , and that in (my) <u>team</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did not</u> view the body after death.										
22b. SIGNATURE <u>Joseph D. Connor, MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>May 21, 1986</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH D. CONNOR, MD</u>			22e. ADDRESS <u>9420 OLD GEORGETOWN RD Bethesda MD 20814</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey 7557 Wisconsin Ave. Bethesda, MD 20814						25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE <u>John T. Anderson</u>		

BP



BRAIN TUMOR TO WORK 12/1/48
LACKED STAMPAH KENDAK 3/2/48
TO WORK

28+1002 28+1002

28+1002 28+1002
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00-06859

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14975

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Farold R. Norris			2a. DATE OF DEATH MONTH DAY YEAR May 12, 1986		2b. HOUR 12:30 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1912		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5100 Dorset Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Nat. Educ. Assn.				
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Chevy Chase		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5100 Dorset Avenue/20815				
14. FATHER'S NAME FIRST MIDDLE LAST Levi --- Norris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida --- Duncan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 512-01-3262		17. INFORMANT ADDRESS Marie T. Norris, Same address as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) Probably APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months 6 months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 1971 19 to 5-12 19 86 , that (I) (we) last saw the deceased alive on 5-11 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE Russell M. Tilley, Jr.		DEGREE M.D.		22c. DATE SIGNED 5-12-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley		22e. ADDRESS 4701 Mass. Ave, NW, Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/12/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD						
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 16 1986 Julia Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100-10000

NAME	DATE	TYPE	STATUS	REMARKS
James Chase	1915	USA	Monte	2100 Dorset Avenue
Levi	--	Monte	Ida	2100 Dorset Avenue
Lee	1915	Monte	Ida	2100 Dorset Avenue
Levi	--	Monte	Ida	2100 Dorset Avenue
Lee	1915	Monte	Ida	2100 Dorset Avenue

4701 Lane Ave, NW, Washington, D.C.

Harrell M. Talley

2100 Wisconsin Ave, NW, Washington, D.C. 20036
Joseph Lawler's Sons, Inc.
2100 Wisconsin Ave, NW, Washington, D.C. 20036
May 18 1988

00-08522

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- REGISTRAR FOR STATE		REG. NO. 14976	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jon O. Nusser		2a. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR 5 17 86 2b. HOUR 9 46 8 M	
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 1 44	6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.
7a. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		10. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
11. CITY OR TOWN OF DEATH Rockville		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paramedic	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery	
13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 501 Rock Lodge Rd.		13f. STREET ADDRESS 20877	
14. FATHER'S NAME FIRST MIDDLE LAST James J. Nusser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera M. Kelsey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1963-1967 571-70-0011	
17. INFORMANT ADDRESS Victoria G. Nusser Gaithersburg, Md. 20877		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE John Tauber		TITLE (SPECIFY) M.D. Deputy	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		DATE SIGNED 5-17-86 Bethesda Md.	
ADDRESS 8218 Wisconsin Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/18/86	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.	
24. FUNERAL DIRECTOR Gossalt H. Sandison Gartner Sandison F.H. Gaithersburg, Md. 20877		25a. DATE REC'D. BY REGISTRAR MAY 23 1986	
25b. REGISTRAR'S SIGNATURE John Tauber			

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• **Abstract**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

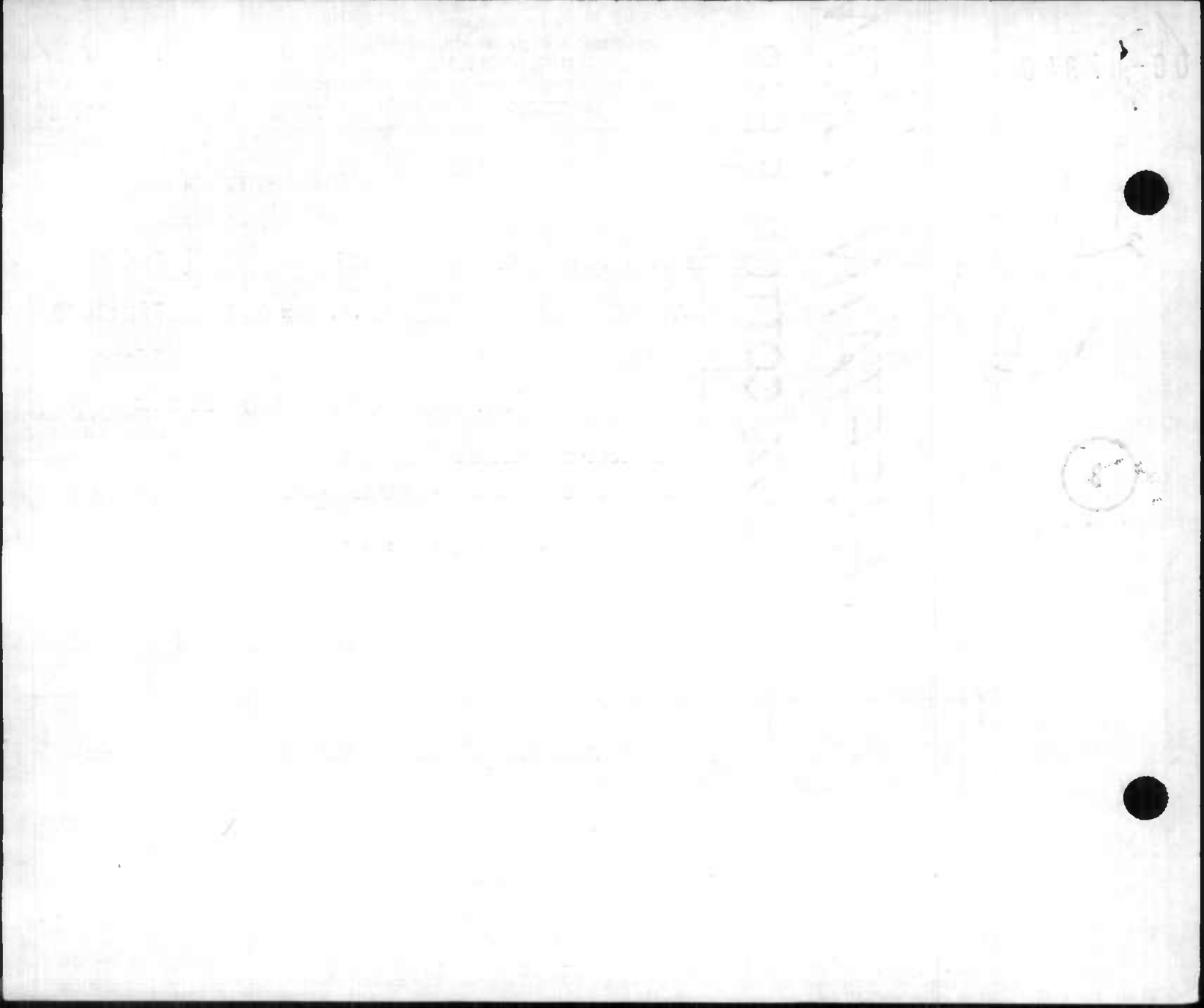
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14977

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JOSE ANTONIO ORLICH		MAY 21, 1986		11:02 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	WHITE	MAY 24, 1950	35 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Costa Rica	Costa Rica		MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	THE CLINICAL CENTER, NIH	Business	Coffee		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
COSTA RICA	None	SAN JOSE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	P.O. Box 3997 Zip: 1000	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Antonio	Orlich	None			
17. INFORMANT	ADDRESS				
MRS. MARIA ORLICH (WIFE)	SAME AS ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Idiopathic Hypereosinophilic Syndrome</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal and Hepatic Dysfunction</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JULY 2, 1985</u> to <u>MAY 21, 1986</u> , that <u>xxx</u> (we) lost saw the deceased alive on <u>MAY 21, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <u>xxx</u> (we) did <u>xxx</u> view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED		
<u>K. Randall Young, Jr., MD</u>			May 21, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
K. Randall Young, Jr., MD	NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	May 24, 1986	Jardines-Del Recuerdo	San Jose Costa Rica		
24. FUNERAL DIRECTOR					
Robert A. Humphrey Funeral Homes					
P.A. 7557 Wisconsin Avenue, Bethesda, MD					
MAY 22 1986					



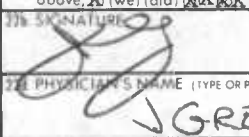

00-07671

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6 1 4 9 7 8		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY ORNDORFF				2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1986		2b. HOUR 4:45			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 3, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teller		12b. KIND OF BUSINESS OR INDUSTRY Capon Valley Bank			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WEST VA.		13b. COUNTY Hardy		13c. CITY OR TOWN WARDENSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 12 26851	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Harmon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva M. (Unavailable)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-42-0232		17. INFORMANT ADDRESS MR. JOHN W. ORNDORFF (HUSBAND) SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 21 , 19 86 , to MAY 20 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 20 , 19 86 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
23. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/20/86			
23b. PHYSICIAN'S NAME (TYPE OR PRINT) J. GREENBERG		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20892							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 23 May 86		23c. NAME OF CEMETERY OR CREMATORY Greenfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wardensville, West Virginia			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		25a. DATE REC'D BY REGISTRAR MAY 27 1986		25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84
(VR 15, 4)

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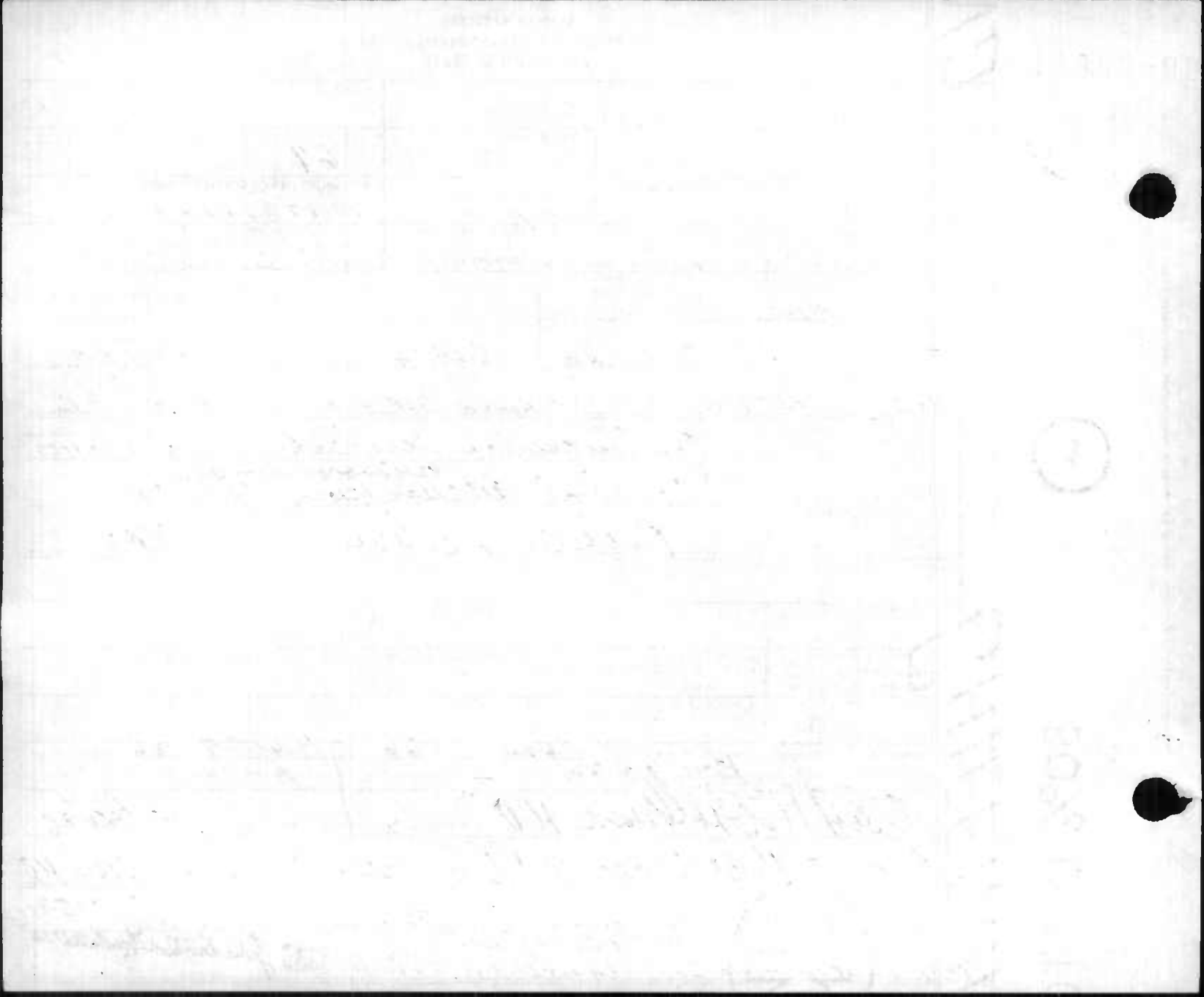
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8614979 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William FRANCIS OSBORNE					2a. DATE OF DEATH MONTH DAY YEAR 5 29 86			2b. HOUR 3 ⁰⁰ PM		
3. SEX M		4. RACE White male		5. DATE OF BIRTH MONTH DAY YEAR 3 12 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SAUER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRLAND NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONST. SUPER		12b. KIND OF BUSINESS OR INDUSTRY CONST.		
13a. STATE MD					13b. COUNTY MONT.		13c. CITY OR TOWN BURTONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. OSBORNE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA JONES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1944		17. INFORMANT RONNIE OSBORNE		ADDRESS SAME AS 13c				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Debrile Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WKS TO MOS. YRS. YRS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from April 19 86, to May 27 19 86, that (I) (we) last saw the deceased alive on May 16 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Albert H. Grollman MD		DEGREE		22c. DATE SIGNED 5/30/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT H. GROLLMAN MD				
22e. ADDRESS 1106 Spring St. Burtonsville MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY BURTONSVILLE MONT.				
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME INC.		ADDRESS 4601 SANDY SPRING RD. LAUREL MD.		25. DATE REC'D. BY REGISTRAR JUN 2 1986						



00-08610

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate, page 1 and 2, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614980
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATIE MASON OWENS		2a. DATE OF DEATH MONTH DAY YEAR 5 25 86		2b. HOUR 3:30 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 14, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Ashton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 126 Ashton Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Montg	13c. CITY OR TOWN Ashton	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST ? MASON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 224-72-7955		17. INFORMANT ADDRESS Maggie O. Love - SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Traumatic Decubiti					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 mos 3 mos
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/25/86 to 5/25/86 , that (I) (we) lost saw the deceased alive on 5/25/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE C. H. Ligon MD		DEGREE		22c. DATE SIGNED 5/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Ligon MD		22e. ADDRESS 18111 Pr Philip Dr, Olney MD 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 5-28-86	23c. NAME OF CEMETERY OR CREMATORY Brown Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Lawrenceville, VA	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR JUN 2 1986	
		25b. REGISTRAR'S SIGNATURE John Davidson			

00-07856

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Their place should be detached for use as the burial permit. Their place should be detached for use as the burial permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR MIN.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR MIN.			
FRED D. PALMER		MAY 24 86				12:18 PM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE	B	5 2 12		72 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
	US			Mont Co MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK MD	WASHINGTON ADVENTIST HOSPITAL			RETIRED			PRIVATE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
WASH. DC	D.C.					411 EAST WAYNE AVE S.S. MD			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
JAMES E. PALMER		MARY CROCKER		NO					
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
UNK.		JAMES H. LUCAS 5618 First St. N.W. Wash D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>									<u>Months</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>									<u>Months</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>									<u>Months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus Pleural effusion RENAL FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
5-6-86 5-14-86		Gangrene right foot		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 5/24 1986, to 5/24 1986, that (I) (we) lost the deceased alive on 5/24 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Kenneth Crige MD.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				5-25-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
KENNETH CRIGE				7600 CARROLL AVE. TOKOMA PK. MD.					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		5-30-86		LINCOLN CEMETERY		SUITLAND, MD.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. DATE REC'D. BY REGISTRAR			
JOHNSON & JENKINS 716 KENNEDY ST. N.W. WASH D.C.				MAY 28 1986					

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0-06658

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

14982

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DANIEL H. PARKER			2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1986		2b. HOUR 1:10 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 26, 1955		6. AGE (IN YEARS (LAST BIRTHDAY)) 31 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY PRINTING CO.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEORGES 13c. CITY OR TOWN GLENN DALE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 6837 GLENWOOD COURT 20769									
14. FATHER'S NAME FIRST MIDDLE LAST PAUL PARKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES THOMPSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-48-3088		17. INFORMANT (FATHER) ADDRESS 22601 PAUL PARKER, BOX 409 SILER RT., WINCHESTER, VA.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

KAPOSI'S SARCOMA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 Mo.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) AIDS

18 Mo.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/9/86, 19, to 4/11/86, 19, that (I) (we) lost saw the deceased alive on 4/10/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wesley B. Mason M.D.				22c. DATE SIGNED 5/12/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wesley B. Mason	
22e. ADDRESS 10500 Summit Ave Kensington MD				22f. ADDRESS			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/14/86		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PG MD	
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009				25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE R. Anderson	

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00-07331

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 4 9 8 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby Russell Patteson			2a. DATE OF DEATH MONTH DAY YEAR 05-16-86		2b. HOUR 1:35 pm
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-01-99		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Assistant		12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.
13a. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10225 Kensington Pky 20895 #903	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Russell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma McSwain			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-48-4278	17. INFORMANT ADDRESS Linda R. Patteson Daughter Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) INTERSTENTIAL OBSTRUCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 2 days 4 1/4 / 86					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BRAIN ATROPHY					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4 14 86 19 86 to 5 16 86 19 86 that (I) (we) lost saw the deceased alive on 5 15 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE C Feinstein MD		DEGREE MD		22c. DATE SIGNED 5 16 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Feinstein, Claud		22e. ADDRESS 18711 Prince Philip dr Olney 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 19, 1986	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986			
		25b. REGISTRAR'S SIGNATURE L. E. Finkler-Rodell			

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05

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper (Page 1) and it should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614984
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Marvin		NMI Payne		May 15, 1986		9:58		am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		October 17, 1908		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		United States				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		Chauffeur		Law Firm			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST				FIRST MIDDLE LAST		14426 Bauer Drive 20853			
Eldridge				Payne		Annabelle Hackley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		577 10 2040		Wife		Katherine D. Payne same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>160 min</u> <u>7 days</u> <u>yes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Congestive Heart Failure, Atrial Flutter/Fibrillation, Diabetes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				5/8 86 5/15 86					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/8</u> 19 <u>86</u> to <u>5/15</u> 19 <u>86</u> that (I) <u>was</u> lost saw the deceased alive on <u>5/15</u> 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated (above) (I never did) (did not view the body after death)									
22b. SIGNATURE <u>Roger F. Leonard MD</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/15/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roger F. Leonard</u>				22e. ADDRESS <u>10401 Old Georgetown Rd., Bethesda MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		May 17, 1986		Gate of Heaven Cemetery		Silver Spring Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave., Rockville, Maryland				MAY 19 1986					

Name		Address		City		State		Zip	

00-08664

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

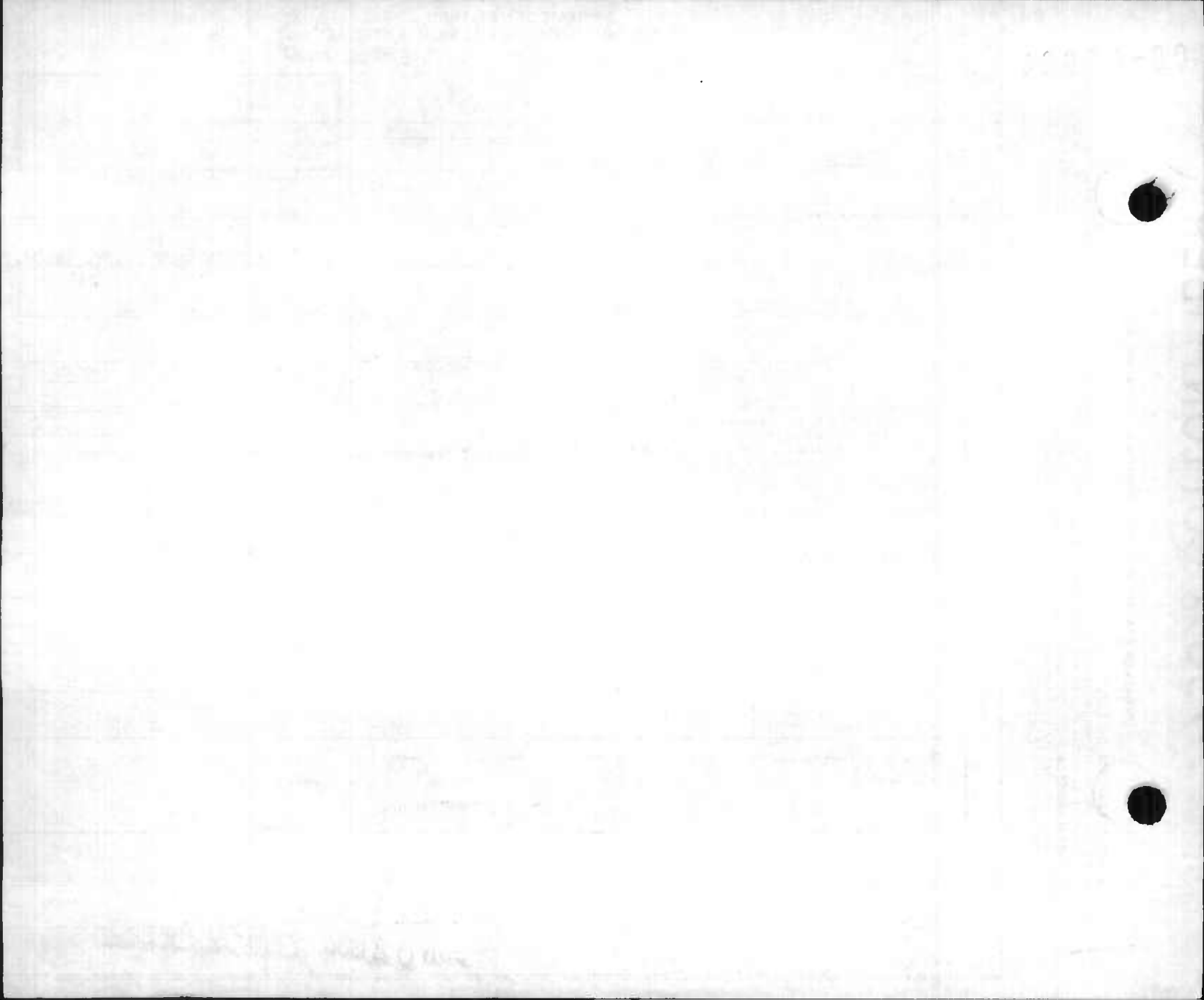
14985

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Jeffrey A. Perper			XX MONTH DAY YEAR 5-24 19 86			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	White	10 16 50	35 YRS.			5-24 19 86	1:50 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.			USA			Montgomery County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Bethesda			Suburban Hospital			Chemical Researcher Amer. Univ.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Montgomery			Potomac		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT		
Arnold Perper			Ruth Raizes			Rockville, Maryland 20852		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			578-72-4928			Ruth Perper 11430 Strand Dr., #3		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Blunt Trauma to Chest								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES XX NO	
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY approx. HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			1:00XX 5-24 19 86		driver in auto/fixed object impact			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK XX			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
			road		Persimmon Tree Road, Montgomery Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident XX, Suicide, Homicide, Undetermined manner.								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Dennis F. Smyth, M.D.			Assistant			5-24-86		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			May 27, 1986		Adas Israel Cong. Cem.		Washington, D.C.	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR			
Dazansky-Goldberg Mem. Chps.			1170 Rockville Pike		JUL 10 1986			
			Rockville, Md 20852					

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DHMH - 17
(VR A15 ME (5))



00-08160

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 9 8 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH Pearl Mierley PETERSON										20. DATE OF DEATH MONTH DAY YEAR 5 29 86		26. HOUR 12 18 A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 19 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Register Nurse		12b. INDUSTRY OR BUSINESS OR PUBLIC SCHOOLS Washington D.C. Public Schools					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10618 Edgewood Avenue 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Loraine Mierley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Chilcote									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-24-6463		17. INFORMANT ADDRESS Edward M. Peterson Husband Same As 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>SEVERE PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UREMIA - RENAL FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>SEPSIS (PSEUDOMONAS)</u>													
19a. DATE OF OPERATION 5/7/1986		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ARTERY DISEASE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>86</u> , to <u>May 29</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jamir R. Neimat</u>				DEGREE M.D.				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMIR R. NEIMAT, MD.				22e. ADDRESS 10313 GEORGIA AV. SILVER SPRING, MD, 20902									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. Maryland							
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JUN 2 1986							

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED EXCEPT WHERE SHOWN
OTHERWISE

03100-0



00-06599

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14987
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Elizabeth M. Phillips</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>05 11 86</u>		2b. HOUR <u>3:40 PM</u>
3. SEX <u>Female</u>	4. RACE <u>CAUCASIAN</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>8 17 25</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS. MONTHS <u>1</u> DAYS <u>1</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County MD</u>	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>NURSE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HEALTH</u>
13a. STATE <u>MD</u>	13b. COUNTY <u>MONTGOMERY</u>	13c. CITY OR TOWN <u>KENNINGTON</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>5113 FLANDERS AVENUE 20895</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Stanley Bartol</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Cornelia Chihocski</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>579-44-1197</u>		17. INFORMANT ADDRESS <u>Alton L. Phillips, same as #13</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRACRANIAL PRESSURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 2 DAY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>—</u>					
19a. DATE OF OPERATION <u>5-7-88</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CAROTID STENOSIS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <u>—</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>— N/A 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, ITEM 18, PART I OR PART 2) <u>N/A</u>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <u>—</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>	
22a. I certify that (I) (the hospital) attended the deceased from <u>4/10</u> 19 <u>86</u> to <u>5-11</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					

22b. SIGNATURE <u>Francis C. Mayle Jr.</u>		DEGREE <u>—</u>	22c. DATE SIGNED <u>5 11 86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANCIS C MAYLE JR</u>		22e. ADDRESS <u>8200 Wisconsin Ave Bethesda MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>May 15 1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 15 1986</u>	
25b. REGISTRAR'S SIGNATURE <u>James E. Henderson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. The certificate is not valid until it is filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified of this.



00-06143

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 4 9 8 8

1. DECEASED NAME (TYPE OR PRINT) GERALD HENRY PHILLIPS			2a. DATE OF DEATH MONTH DAY YEAR MAY 5 1986		2b. HOUR A M 4:45 A
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 20 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY STATE POLICE
13a. STATE W. VIRGINIA	13b. COUNTY UPSHUR	13c. CITY OR TOWN BUCKHANNON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RT 3, BOX 350A 26201	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN JACK PHILLIPS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA EDITH SIMMONS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1941-1946 232-18-4969		17. INFORMANT ADDRESS MILDA M. PHILLIPS, RT 3, BOX 350A, BUCKHANNON,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 28 , 19 86 , to MAY 5 , 19 86 , that (I) (we) last saw the deceased alive on MAY 5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J.P. Mehegan</i>		DEGREE MD		22c. DATE SIGNED 5 MAY 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MEHEGAN, LT, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 8, 1986		23c. NAME OF CEMETERY OR CREMATORY Roger Chapel Church Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Buckhannon, West Virginia					
24. FUNERAL DIRECTOR NAME Poling-St. Clair Funeral Home 95 South Kanawha Street, Buckhannon, WV				25a. DATE REC'D. BY REGISTRAR MAY 12 1986	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

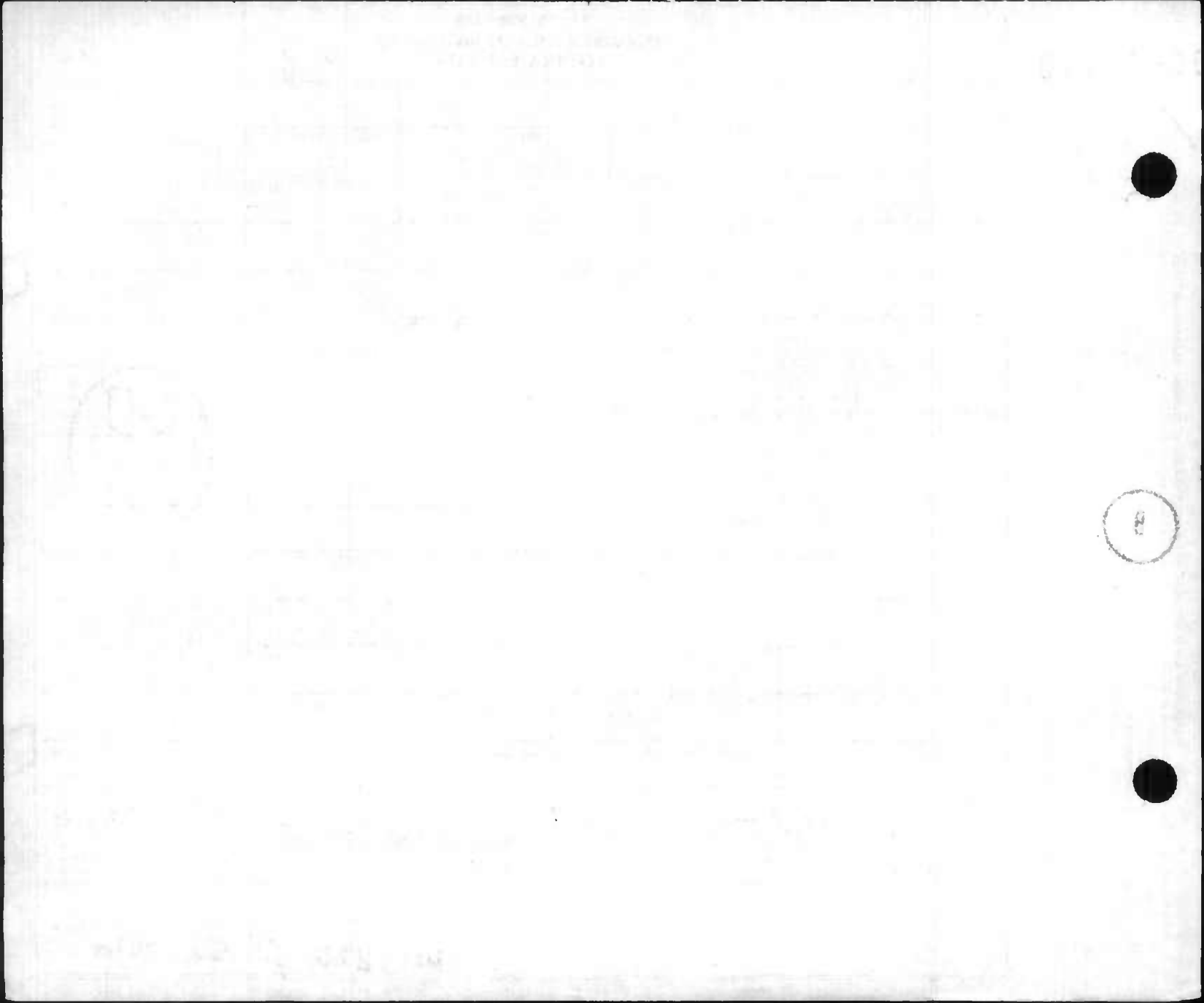
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 HUNTERSTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06941

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

14989

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK D. POLLARD			2a. DATE OF DEATH MONTH DAY YEAR 05-11-86		2b. HOUR 6:55A.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN. 27, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MDNTGOMERY Co. MD.
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SURBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY TAXES
13a. STATE Md.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 2215 WESTVIEW DR. 20910		14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. POLLARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA HUGHES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 084-22-9846A		17. INFORMANT ADDRESS FREDERICK D. POLLARD JR (SAME AS #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nephritis DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: pneumonia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Bethesda 20817		
22a. I certify that (1) (this hospital) attended the deceased from above; (2) (my) (did) (did not) view the body after death; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.						
22b. SIGNATURE Thos G. Ward M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/11/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD		22e. ADDRESS 6116 Robinson Rd Bethesda 20817				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-13-1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS Co. INC. SILVER SPRING, MD.				25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-07645

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14990

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DEBORAH LEE POSNER			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5-18-86		2b. HOUR M 10:50A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 10, 1957	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 28	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. XX	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. XX
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10113 Devere Ct.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Off.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Posner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bess S. Slavin		16. SOCIAL SECURITY NO. 218-78-9603	
17. INFORMANT Bernard Posner (Same as # 13)		18. ADDRESS 10113 Devere Court		19. DATE REC'D. BY REGISTRAR MAY 22 1986	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Gunshot wound of head**
 (b) _____
 (c) _____
 CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-17-86	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self/.inflicted
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10113 Devere Ct. Silver Spring, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

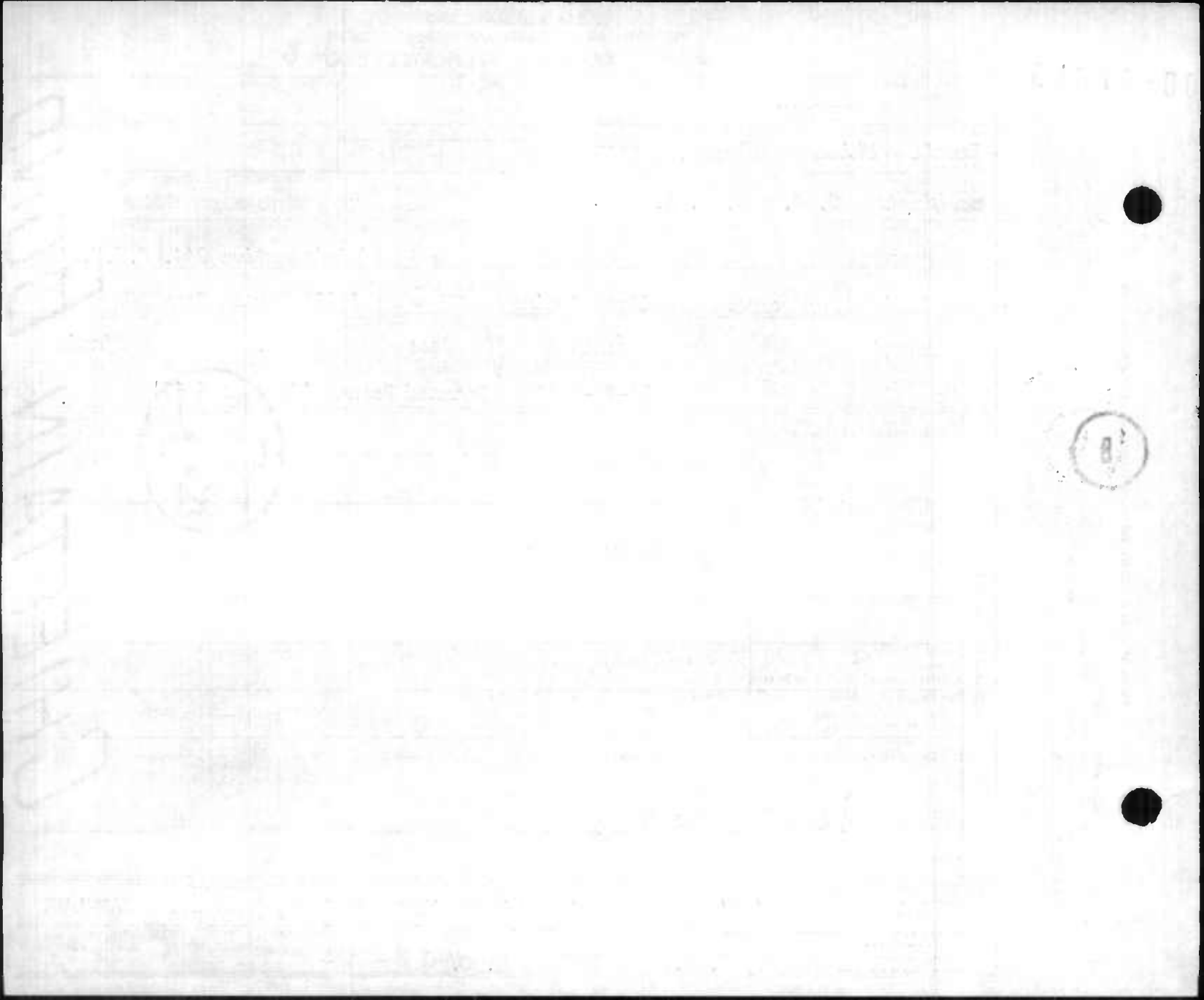
ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) **Assistant** M.D. **Assistant** MEDICAL EXAMINER DATE SIGNED **5-19-86**

EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL	23b. DATE 5/21/1986	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY	23d. LOCATION COUNTY STATE PRINCE GEORGE'S, MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>		25c. REGISTRAR'S SIGNATURE <i>J. Davidson</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. BETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



00-07310

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6										REG. NO. 14991									
1- FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Patricia McLean Powell										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 5 1986		2b. HOUR 6:30 P M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 29 21		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YR. MONTHS DAYS 64 YRS.		IF UNDER 24 HRS. HOURS MIN 64 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 5 1986		7d. HOUR 6:30 P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Australia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 7407 Ridgewood Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE MD				13b. COUNTY Montgomery				13c. CITY OR TOWN Chevy Chase				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 7407 Ridgewood Ave./20815			
14. FATHER'S NAME FIRST MIDDLE LAST Alick McDonnell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Sargent Dyer				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 094-24-5338				17. INFORMANT ADDRESS Richard M. Powell, Same address as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 5-6-86											
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/7/86				23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR MAY 19 1986				25b. REGISTRAR'S SIGNATURE John Tauber											
5130 Wisconsin Ave., NW, Washington, D.C. 20016																			

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Law 2

Kontagorov,

esnd yvnd

0-06335

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clara E. Prather			2a. DATE OF DEATH MONTH DAY YEAR May 1 1986		2b. HOUR 10:09P
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 3 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Day			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-84-2158		17. INFORMANT Dorothy Rigney	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) did not attended the deceased from May , 19 79 , to May 1 , 19 86 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on January 6 , 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <i>Cheryl Winchell MD</i> DEGREE				22c. DATE SIGNED 5/2/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Cheryl Winchell				22d. ADDRESS Gaithersburg, Md. 19241 Montgomery Village Ave. 20879	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 5, 1986	23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem. Suitland P.G. Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <i>Wanda Henderson</i>	

MEDICAL CERTIFICATION

902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

00-06293

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div> <div>1- FOR STATE REGISTRAR</div> <div>8 6 1 4 9 9 3</div> <div>REG. NO.</div> </div>											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH			2b. HOUR		
ROBERT Eugene PRATHER						MONTH DAY YEAR			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		Black		Aug. 8, 1942		43		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
MD				USA				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Rockville				Shady Grove Hospital				Laborer			
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD						Montg.		Brookeville		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY			
Charles Prather						Rosie Dorsey		20833			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes						Vietnam		220-40-3968			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
<i>Dennis F. Smyth</i>				M.D. Assistant				5-1-86			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Dennis F. Smyth, M.D.				111 Penn St., Balto., MD				21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				5-5-86		Brooke Grove Cem.		Laytonsville, Montg. MD			
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR							
George R. Snowden				246 N. Washington St				MAY 08 1986			
Rockville, MD				20850							

30587-10



00-08206

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

For Dr. J. Egan

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a carbon copy, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14994
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MARY MIDDLE Durfee LAST PRATT		MONTH DAY YEAR 05 31 86		10 40 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 30, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Durfee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Keith		13e. STREET ADDRESS / ZIP CODE 6 North Drive/20814			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-58-5588		17. INFORMANT ADDRESS Arnold W. Pratt, M.D., same as #13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN STEM INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Embolism DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Respiratory failure. Severe Multiple sclerosis							
19a. DATE OF OPERATION		19b. CONDITIONS FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/25, 1986, to 5-31, 1986, that (I) (we) lost saw the deceased alive on 5-31, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Bahar		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR MD		22e. ADDRESS 8218 Wisconsin Ave. Beth. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 2 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey 7557 Wisconsin Ave. Bethesda, MD 20814 PA				25a. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson	

1750

1050-01

1750

1750

1050-01

00-05981

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. J 4995

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
Cecilia K. Prescott			
2. DATE KNOWN OF DEATH	MONTH	DAY	YEAR
ESTIMATED	5	4	86
2b. HOUR	7:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	10 1 08	77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	United States		Montgomery MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	5106 Wilson Lane	Homemaker	Own Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland	Montgomery	Bethesda	13e. STREET ADDRESS
5106 Wilson Lane/20814			
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Antek	Kubacki	Josefa Madalinska	
17. INFORMANT		999 E. Flamingo #57	
No		Robert K. Prescott Las Vegas, NV	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cardiac Arrest			
DUE TO, OR AS A CONSEQUENCE OF			
(b) coronary arteriosclerosis			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE	TITLE (SPECIFY)	M.D.	DATE SIGNED
John Tauber	Deputy		5-4-86
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
John Tauber	8218 Wisconsin Ave		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	May 7, 1986	Rockville Cemetery	Rockville, Maryland
24. FUNERAL DIRECTOR'S NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTERED	
Robert A. Pumphrey Funeral Homes	MAY 8 1986		
7557 Wisconsin Ave. Bethesda, MD 20814PA			

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

11-12-16

C

00-07252

12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

14996

1. DECEASED NAME (TYPE OR PRINT) Benjamin L. Prins			2a. DATE OF DEATH MONTH 5 DAY 15 YEAR 86			2b. HOUR 8 MIN 15			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH July DAY 24 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS 8 DAYS 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Holland		7b. CITIZEN OF WHAT COUNTRY? Holland		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Industry Bank	
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST Liepmann MIDDLE Prins LAST Prins					15. MOTHER'S MAIDEN NAME FIRST Judith MIDDLE Schaap LAST Schaap				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 066-16-9809		17. INFORMANT ADDRESS Silver Spring, Md. Hilde M. Prins; 2445 Lyttonsville Rd., #906;				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, Parkinsonism, chronic bronchitis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/23 19 86 to May 15 19 86 , that (I) (we) last saw the deceased alive on 5/14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Herman B. Segal MD					DEGREE MD			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herman B. Segal MD					22e. ADDRESS 10313 Georgia Ave Silver Spring Md 20916				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/16/86		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE H. Davidson		

BP

SPY 10-0

2



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

00-06602

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14997

1- STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b MONTH DAY YEAR		2c HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
BERNADETTE						Gruhl	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Female	White	JULY 26 1913	72			MAY 11 1986	10:20
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.	USA			Montgomery MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring	Holy Cross Hosp.	CONTROLLER STATE DEPT.		STATE DEPT.			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
MD	Montgomery	Silver Spring		716 WHITAKER TERRACE 20901			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
THOMAS	ANN	NO		577-24-3806		JOSEPHINE L. QUILL SISTER SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
<u>John S. Rogers</u>		M.D. <u>Dep't</u>				MAY 11 1986	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
JOHN S. ROGERS		1919 SEMINARY ROAD SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		MAY 15, 1986		MT. OLIVET CEMETERY		WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS FUNERAL HOME, INC.		MAY 15 1986		<u>Francis J. Collins</u>			
500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALCOHOL, TOXICOLOGY, AND DRUGS, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 9 9 8

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) GEORGE STEPHANOS RADOS			3a. DATE OF DEATH MONTH DAY YEAR 5/14/86			3b. HOUR 6:45 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 27 17			6. AGE (IN YEARS LAST BIRTHDAY) 68		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11915 Andrew Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OF INDUSTRY Smith's Pie Company		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11915 Andrew Street 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Stephanos G Rados		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Bellas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 577-01-8523		17. INFORMANT ADDRESS Helen G. Rados Wife Same as above						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CANCER OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF (c):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): CONVENTIONAL BILIARY DYSKINESIS										
19a. DATE OF OPERATION 12/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLELITHIASIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5113 2/19 71 to 5114 86						
22a. I certify that (I) (this hospital) attended the deceased from 5/13 1986 to 5/14 1986 , that (I) (we) lost saw the deceased alive on 5/13 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23a. SIGNATURE David Goldenberg MD		23b. DEGREE MD		23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23d. DATE SIGNED 5/14/86			
23e. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDBERG MD		23f. ADDRESS 8801 CROFT SILVER SPRING, MARYLAND 20902								
23g. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23h. DATE May 16, 1986		23i. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23j. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr.				24b. ADDRESS 500 University Blvd. West Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove copy of pages 1 and 2, should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			3. SEX			4. RACE		
Ruth H. RAINES			5 29 86			FEMALE			WHITE		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. DATE OF BIRTH			9. AGE (IN YEARS LAST BIRTHDAY)		
PENNA			U.S.A			MAY 7 1907			79 YRS.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASHINGTON ADVENTIST HOSPITAL			HOMEMAKER					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD			ANN ARUNDEL			ANAPOLIS			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		
FRANK			ANNA			220-48-2197			LINDA ANN MCLAUGHLIN, 505 BELFORD PL. TAKOMA PARK		
18. CAUSE OF DEATH			19. DATE OF OPERATION			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Surgery DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Renal Failure, Diabetes Mellitus, Hypertension			4/26/86			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. PLACE OF INJURY		
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			P.M. 19			ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/26/86 to 5/29/86, that (I) (we) last saw the deceased alive on 5/29/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)		
			Gregory H. Fisher M.D.			5/29/86			Gregory H. Fisher		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL			JUNE 2 1986			George Washington Cemetery			Adelphi, Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S NAME		
TAKOMA FUNERAL HOME			J. A. Whelan			J. A. Whelan			J. A. Whelan		

NAME: [illegible]
ADDRESS: [illegible]
CITY: [illegible]
STATE: [illegible]
ZIP: [illegible]

FROM: [illegible]

NO. [illegible]

DATE: [illegible]

TO: [illegible]

RE: [illegible]

ATTENTION: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

00-07408

 items 13a thru 13e,
 FOR STATE film#G615-5/28/86
 REGISTRAR jlb

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 86 15000
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ellsworth H. Rapee			2a. DATE OF DEATH MONTH DAY YEAR May 20 1986			2b. HOUR 11:A. M	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 703 Kenbrook Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Postal Service		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. US (STATE) RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. Fairfax		13c. Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Rapee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Lusby		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (TOWN) N/A		16b. SOCIAL SECURITY NO. 577-18-8761	
17. INFORMANT Brenda R. (daughter)		18. ADDRESS 3917 Wendy Lane, S.S. Md.		20906			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma				2 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of colon				4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 30, 1980, to May 8, 1986, that (I) (we) lost saw the deceased alive on May 8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)					
22b. SIGNATURE Thomas F. Cullen		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 22, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Cullen, MD		22e. ADDRESS 5103 Marlboro Pike, Capitol Hgts. Md. 20743			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR MAY 22 1986		25b. REGISTRAR'S SIGNATURE John Davidson	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please render the body to the funeral home. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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No.		Name		Description		Quantity		Value	

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

15001

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edison Howard Raymore			2a. DATE OF DEATH MONTH DAY YEAR May 5; 86		2b. HOUR 7:09 pm
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 19 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Panama	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD
10. CITY OR TOWN OF DEATH Baltimore Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaner		12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Howard - Raymore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda - (Unknown)		16. STREET ADDRESS / ZIP CODE 14425 Taos Ct. Silver Spring, Md. 20906	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-11-0559		17. INFORMANT ADDRESS Shirley R. Smith 14425 Taos Ct. Maryland 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Possible massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (c) S/P previous abdominal aortic aneurysm					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: S/P aortic femoral popliteal bypass					
19a. DATE OF OPERATION 5/13/86 12:15/1:00		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal aortic aneurysm		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:20/86 19 86		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery MD	
22a. I certify that (I) (this hospital) attended the deceased from 4/20/86 to 5/5/86 , that (I) (we) lost saw the deceased alive on May 5 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JOSEPH F. MARQUEZ MD		DEGREE MD		22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH F. MARQUEZ MD		22e. ADDRESS 1610 Camell Ave Suite 350 TAVOLNA PARK MD 20912			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May/9/86	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE J. J. Anderson-Rodriguez	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified of the cause.

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00-06940

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15002
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Boyd R Read Jr.			2a. DATE OF DEATH MONTH DAY YEAR 05-13-86		2b. HOUR 5:30 A.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bobby Moore Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY C & P Telephone Co.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Boyd R. Reed, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Rinker		13e. STREET ADDRESS / ZIP CODE 301 Taylor Ave 20850			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Cora B. Reed wife		ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Eisanguination - Corotid artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic laryngeal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (11a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70's</u> to <u>5-13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald L. Bucy MD				DEGREE MD		22c. DATE SIGNED 5-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L. Bucy				22e. ADDRESS 809 Veirs Mill Rd. Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. NAME ADDRESS 300 West Montgomery Ave. Rockville, Md. 20850				25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 must also be filled in, or other traumatic event, the medical examiner will be notified at once.

BP

07893

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8.6

REG. NO.

15003

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E Reister			2a. DATE OF DEATH MONTH DAY YEAR May 20 1986		2b. HOUR 12:15p_M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 24 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY Hotel Industry	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Norton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Howard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-46-3794	
17. INFORMANT Frank A. Reister		ADDRESS Boca Raton, Florida		2701 No. Ocean Blvd.		33431	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 3 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 4/8 , 19 86 , to 5/20 , 19 86 , that (I) (we) last saw the deceased alive on 5/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Myron L. Lenkin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myron L. Lenkin		22e. ADDRESS 2309 Shorefield Rd. Wheaton, Md. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 22, 1986		23c. NAME OF CEMETERY Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ross Township Allegheny Pa.	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Handwritten notes and diagrams, including a large circular diagram with internal lines and text, and several smaller diagrams and text fragments.



00-07467

1- FOR
STATE
REGISTRAR

Elsie R. Reynolds

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 5 0 0 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Elsie R. Reynolds		2a. DATE OF DEATH MONTH DAY YEAR May 22 '86		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Rinehart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie unknown		13e. STREET ADDRESS / ZIP CODE 211 Russell Avenue 20877			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 218-34-8838		17. INFORMANT 13616 Bardon Road Thomas K. Rettew Phoenix, Maryland 21131			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22/86</u> <u>May</u> 19 <u>86</u> to <u>date</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/22/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Thos G. Ward M.D.</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/22/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thos G. WARD</u>				22e. ADDRESS <u>6116 Robinson Rd, Bethesda 20817</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>05/24/1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Leonard J. Ruck, Inc. Baltimore, Maryland</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 23 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Swinton-Rodgers</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-00000



00-08644

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

15005

1. DECEASED NAME (TYPE OR PRINT) Joseph Ricketts			2a. DATE OF DEATH MONTH DAY YEAR May 26, 1986		2b. HOUR 4:20 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 15, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Porter		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-26-0394		17. INFORMANT ADDRESS Mary Ricketts (wife) same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DIABETES mellitus					years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Gangrene					
19a. DATE OF OPERATION 5/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE OF PENIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) was attended the deceased from May 8 , 19 86 to May 26 , 19 86 , that (I) met lost saw the deceased alive on May 26 , 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) met did not view the body after death.					
22b. SIGNATURE BARRY HUGHES, MD.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 27, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HUGHES		22e. ADDRESS 3941 FEDERAL DRIVE WHEATON MD 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-30-86		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. MD					
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR JUN 9 1986	
		25b. REGISTRAR'S SIGNATURE J. B. [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove column 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner may be notified of death.

THE UNIVERSITY OF CHICAGO
 LIBRARY

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please immediately return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST				May 15, 1986		7:45A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Female		White		MONTH DAY YEAR Aug. 22 1894		91 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, DC		USA				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Bel-Pre Health Care Center				Typist		Self Employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		705 Orchard Way, 20904	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Frank Ries				Marguerite Kottmann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT (nephew)		ADDRESS			
N/A		N/A		578-01-4313		Francis J. Farley-705 Orchard Way., 20904 S.S. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Chronic Cardiac Nephrosis</i>								5 years	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stroke</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Parkinson's Disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May 10, 1986</i> to <i>May 7, 1986</i> , that (I) (we) last saw the deceased alive on <i>May 10, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) did not view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>Robert C. Haile MD</i>				<i>X</i>		<i>X</i>		<i>5/15/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Robert C. Haile, MD				5100 Wisc. Ave., N.W. Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		May 17, 1986		Gate of Heaven		Silver Spring Montgomery Md.			
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		<i>MAY 19 1986</i>			



00-07001

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

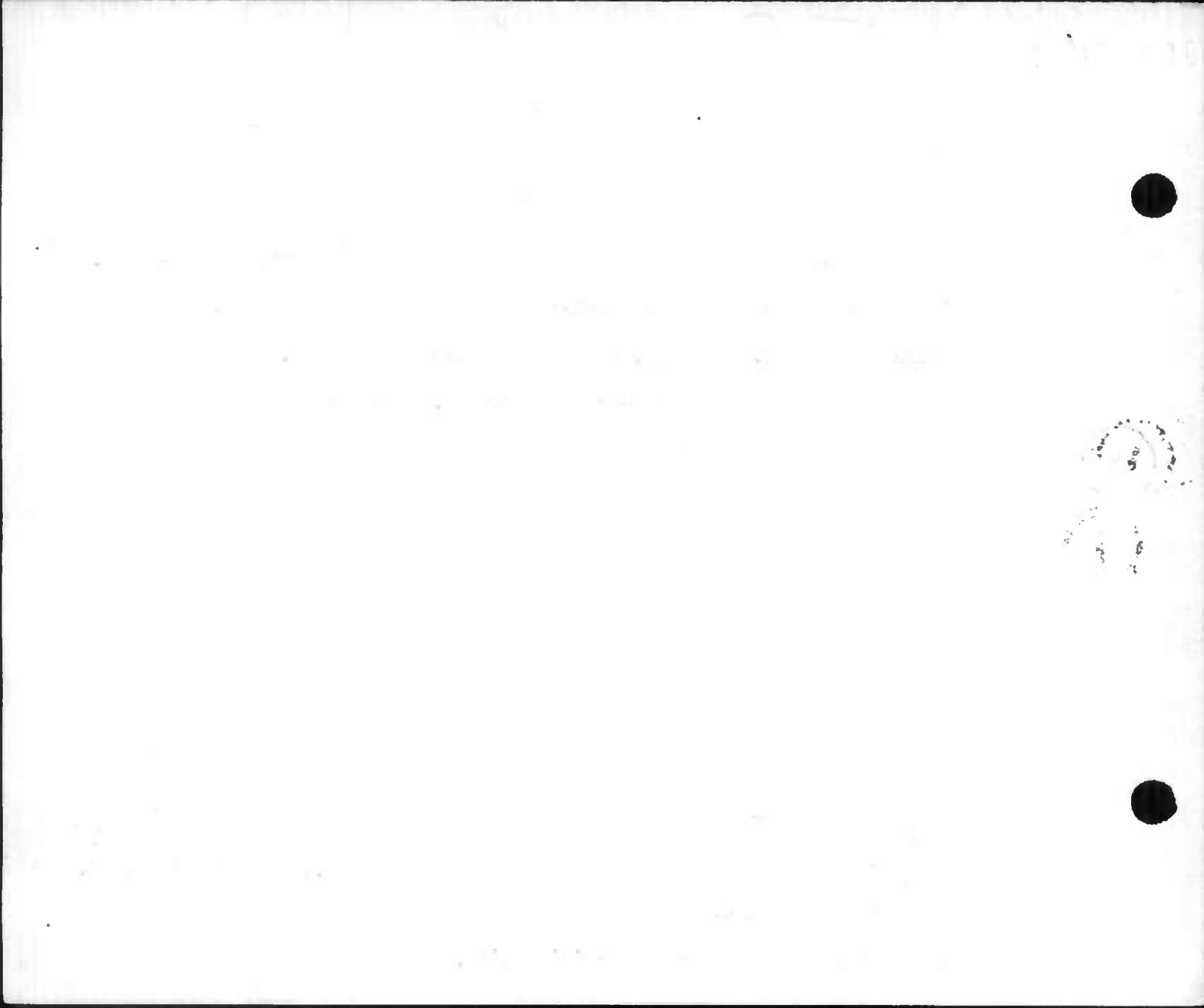
86

REG. NO.

15007

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
FIRST MIDDLE LAST		5 18 86		AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		WHITE		MONTH DAY YEAR	
				01 20 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Pennsylvania		US		66	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Silver Spring		Holy Cross Hosp. 1500 Forest Glen Rd		MONTGOMERY COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (LAST 10 YEARS OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY US Dept. of Agr.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		10414 Royal Road 20903	
Maurice T. Rife		Bernice E. Gable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
yes		WW 11		Nadine E. Rife-wife- (same as 13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		Massive stroke; Brain herniation			
DUE TO, OR AS A CONSEQUENCE OF		Diffuse atherosclerosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
Coronary Disease (2) Pneumonia (3) Left Ventricular Dysfunction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/11/86, 1986, to 5/17/86, 1986, that (I) (we) last saw the deceased alive on 5/11/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE		DEGREE		22c. DATE SIGNED	
Bruce Zinsmeister MD				5/18/86	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BRUCE ZINSMEISTER		8830 Cameron St., Silver Spring, Md. 20910			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY)		23d. DATE		23e. NAME OF CEMETERY OR CREMATORY	
Burial		5-21-1986		Rest Haven Cemetery	
24. FUNERAL DIRECTOR		24a. DATE REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		MAY 19 1986	
25a. LOCATION CITY OR TOWN		25b. COUNTY		25c. STATE	
Hanover				Penna.	

BP



00-08330

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8615008 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BARBARA S. ROBERSON					2a. DATE OF DEATH MONTH DAY YEAR 5-28-86			2b. HOUR MIN. 1:30			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 15 53			6. AGE (IN YEARS LAST BIRTHDAY) YRS 32		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3467 Bantry Way 20832			
14. FATHER'S NAME FIRST MIDDLE LAST Carlton E. Shamburg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Vincent							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Daniel S. Roberson-husband-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid bleed DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Delayed pneumonia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS DURING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/28 , 19 86 , to 5/28 , 19 86 , that <input checked="" type="checkbox"/> the deceased was above, (I) (we) did not view the body after death.											
22b. SIGNATURE A. A. W. W. W. W. W. W.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/28/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. A. W. W. W. W. W. W.						22e. ADDRESS 10313 Georgia Ave Silver Spring MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-29-1986		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg W. Va.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home						ADDRESS 11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR JUN 3 1986		
						25b. REGISTRAR'S SIGNATURE Jane W. W. W. W. W. W.					

RECEIVED

RECEIVED

RECEIVED



00-07265

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 REG. NO.		8 6 1 5 0 0 9		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
John		Colbert		Roberts		May 12, 1986		9:25PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		Caucasian		November 18, 1919		66 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
USA, Virginia		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		Groundskeeper		Soldier's Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16413 New Hampshire Ave. 20904	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Alexandria		Mary		Yes		231-16-3027		Rita Myers, 725 Briggs Chaney Rds., Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Respiratory Failure				3 yr.	
		(c)		Emphysema				5 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 23, 1986, to May 12, 1986, that (I) (we) last saw the deceased alive on May 12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED			
Frank J. Mayo		MD				5-12-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		16220 Frederick Rd. #213							
		G. Thomsburg, Md. 20177							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		5/15/86		Good Hope Bapt. Ch. Cem.		Spotsylvania Co., Virginia			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W.B. Snellings		MAY 19 1986		Julia E. ...					

VESSEL		DATE		TIME		PLACE		REMARKS	
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100

8

00-07272

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

15010

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy Lee Rogerson		2a. DATE OF DEATH MONTH DAY YEAR May 10, 1986		2b. HOUR 10:00 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10 1949		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. County
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Darlington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1103 Stafford Rd. 21034
14. FATHER'S NAME FIRST MIDDLE LAST Luther C. Lassahn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hoffmeyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-56-4605		17. INFORMANT ADDRESS Mr. Paul Rogerson, same	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC OVARIAN CARCINOMA WITH ABDOMINAL DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMATOSIS, PELVIC MASS, LIVER METASTASES APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH 24 HOURS 1 YEAR					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from September 24, 85, to May 10, 1986, that (we) lost saw the deceased alive on May 10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (not) view the body after death.					
22b. SIGNATURE Michael J. Birrer		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Birrer		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-86	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		24a. ADDRESS 7401 Belair Rd. BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR MAY 20 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	

51080-00

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964



00-06346

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 22 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

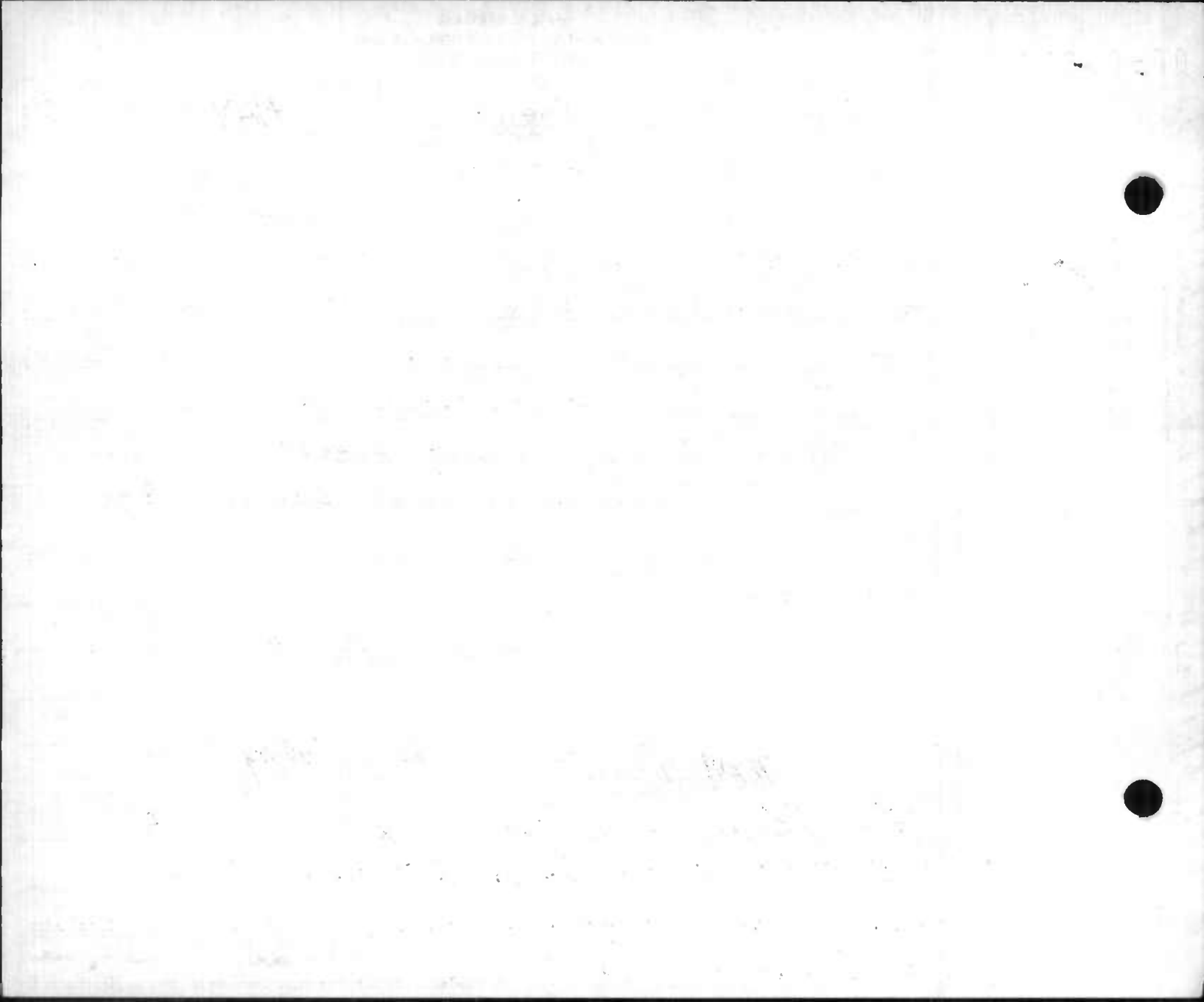
8 6

REG. NO.

1 5 0 1 1

1. DECEASED NAME (TYPE OR PRINT) John Rogue			2a. DATE OF DEATH MONTH DAY YEAR MAY 9 1986		2b. HOUR 1:15 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 8, 1918	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3974 Bel Pre Road, #6		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Customs Broker		12b. KIND OF BUSINESS OR INDUSTRY Import/Export
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Carlos Rogue			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Not available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 213-44-5149		17. INFORMANT ADDRESS Mrs. Gladys Roque, Same as item #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 8 YRS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minute
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 85 , to MAY 9 19 86 , that (I) (we) lost saw the deceased alive on MAY 9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. T. Benack		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 4115 Colie DR. Wheaton MD		22e. ADDRESS R. T. Benack MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN Alexandria		COUNTY Virginia		STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey			25a. DATE RECEIVED BY REGISTRAR MAY 13 1986		
ADDRESS P.A., 300 W. Montgomery Avenue, Rockville, MD.			25b. REGISTRAR'S SIGNATURE [Signature]		

BP



00-07000

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician in and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

BP

DHMH-16 30M 2/80
(VRS 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 5 0 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lloyd F. Rollins			2a. DATE OF DEATH MONTH DAY YEAR May 14, 1986		2b. HOUR 12 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14000 Castle Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NASA-Air. Condition Tech.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Mont. S.S.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Rollins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Newman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 577 05 6354		17. INFORMANT ADDRESS 5110 Beaverbrook Rd. Columbia, Md. Joy Ann Pierlione (Daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CHRONIC PULMONARY OBSTRUCTIVE DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/10 , 19 86 , to 5/14 , 19 86 , that (I) (we) lost saw the deceased alive on 5/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard P. Delaney</i>		DEGREE M.D.		22c. DATE SIGNED 5/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.		22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906.			
23a. BURIAL, CREMATION, REMOVAL (SEE FOOTNOTE) Burial		23b. DATE 5/17/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.		25a. DATE REC'D. BY REGISTRAR MAY 19 1986			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.		25b. REGISTRAR'S SIGNATURE <i>Jana Harrison</i>			



00-08532

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/interment permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

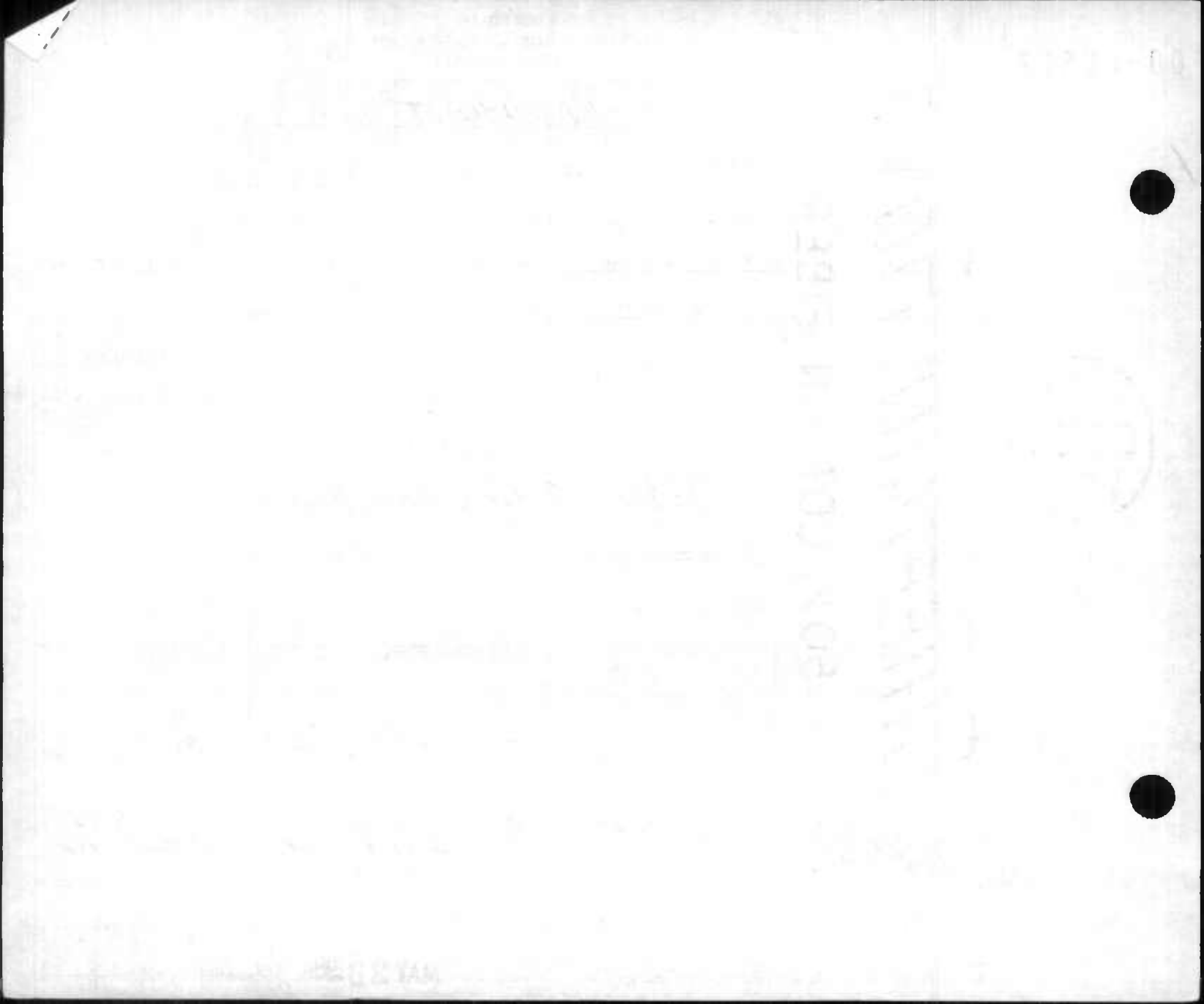
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

15013

1. DECEASED NAME (TYPE OR PRINT) LILLIAN		FIRST MIDDLE LAST ROSENBLATT		2a. DATE OF DEATH MONTH DAY YEAR May 24, 1986		2b. HOUR 4:55p M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Aug 25, 1901		6 AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Navy	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Max Rabin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Pomerantz		13e. STREET ADDRESS / ZIP CODE 299 Hurley Avenue 20858			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 158 09 2795		17 INFORMANT ADDRESS David Rabin (brother) 174-11 73rd Ave, Flushing, Long Island, NY 11366			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 5 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/20 8:24 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/24 8:24 to 5/24 8:24 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		73c. DATE SIGNED 5/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 28 1986		23c. NAME OF CEMETERY OR CREMATORY Judean Mem'l Park		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Ives-Pearson F.H. Falls Church, VA 22046				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson Rindell	

BP



0-0-736-2

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

15014

1. DECEASED NAME (TYPE OR PRINT) MAE S. RYAN			2a. DATE OF DEATH MONTH MAY DAY 18 YEAR 1986		2b. HOUR 920 P.M.
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH Sept DAY 26 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5607 McLean Drive / 20814	
14. FATHER'S NAME FIRST John MIDDLE J. LAST Sweeney		15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE LAST Reagan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 50 6937		17. INFORMANT ADDRESS Rockville, Md. 20855 Wallace A. Sweeney, 18 Oskaloosa Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive upper gastrointestinal bleeding					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) stress ulcer					2 days
DUE TO, OR AS A CONSEQUENCE OF (c) biliary obstruction with sepsis					2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 					
19a. DATE OF OPERATION 5/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED biliary obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from May 18 19 86 to May 18 19 86 that (I) (we) saw the deceased alive on May 18 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marvin Wadler		DEGREE MD		22c. DATE SIGNED May 19, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 21, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Funeral Homes PA. 7557 Wisconsin Av., Bethesda, Md.		25. DATE REC'D. BY REGISTRAR MAY 22 1986	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1-17



00-05916

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0987832 64/30/86 57015

0987832 64/30/86 57015

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald F. Salesky		2a. DATE OF DEATH MONTH DAY YEAR 05-01-86		2b. HOUR 10:25	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03-28-22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Salsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Montgomery		16. ADDRESS 425 C.N. Frederick Ave	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-553		17. INFORMANT Doris Salsky Gaithersburg, MD 20877	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic nephropathy and nephrosclerosis		6 years
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes		Many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, chronic bronchitis, smoking (past), chronic congestive heart failure			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

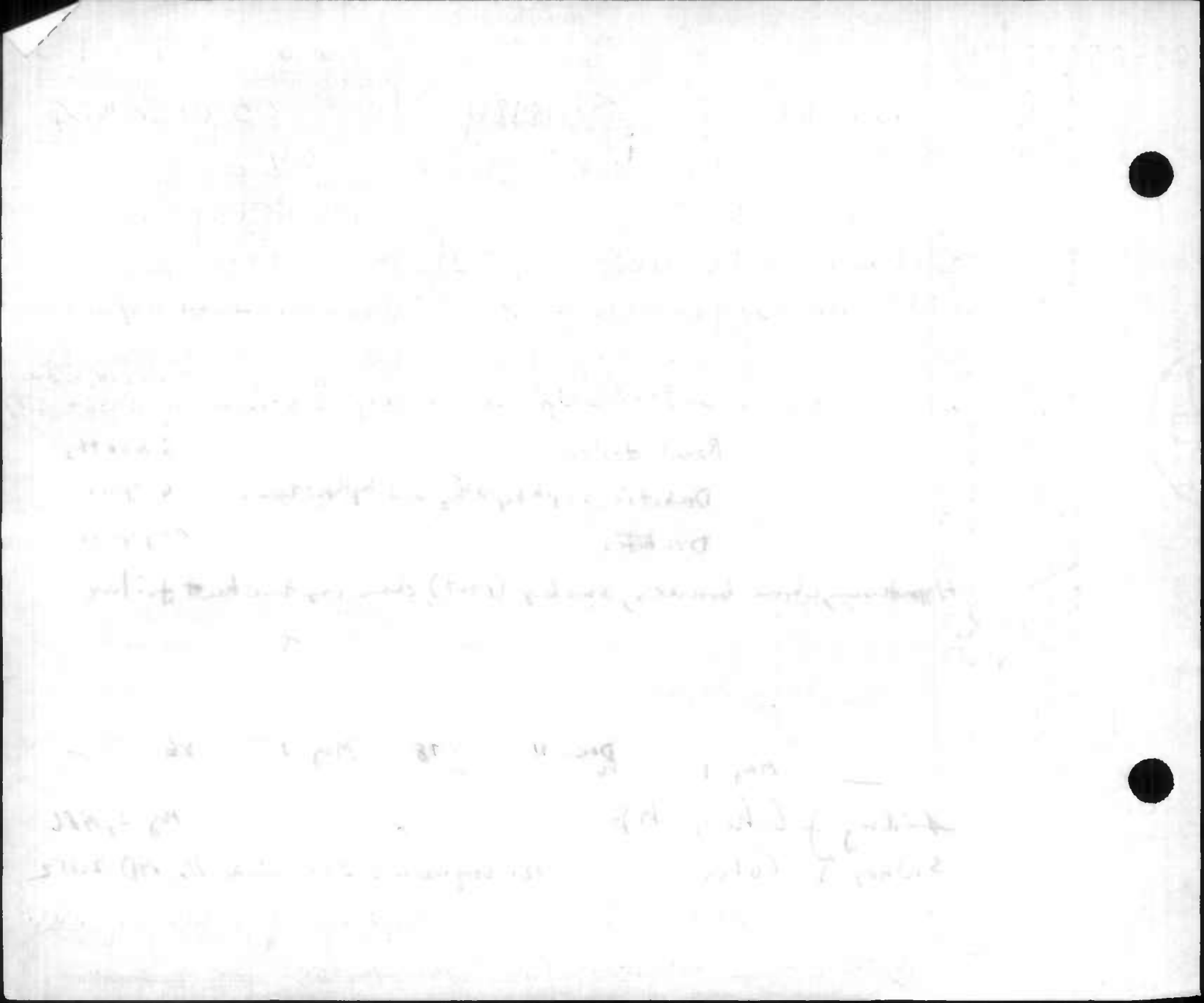
22a. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1978 to May 1, 1986 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on May 1, 1986 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.		22c. DATE SIGNED May 2, 1986
22b. SIGNATURE Sidney J. Cohen, M.D.		22d. ADDRESS 121 Congressional Lane, Rockville, MD 20852
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen		22f. ADDRESS 121 Congressional Lane, Rockville, MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/5/86	23c. NAME OF CEMETERY OR CREMATORY Philos Cornean Westport Allegany MD	23d. LOCATION CITY OR TOWN COUNTY STATE Westport Allegany MD
24. FUNERAL DIRECTOR T. Wayne Boul		25a. DATE REC'D. BY REGISTRAR MAY 7 1986	
25b. REGISTRAR'S SIGNATURE John Davidson		25c. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified in writing.



00-05775

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		JOHN JOSEPH		SANSONE		86 15016 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JOHN		J		SANSONE				MAY 3, 1986		3:20 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		AUGUST 30, 1909		76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
PENN.		USA				MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
OLNEY		MONTGOMERY GENERAL HOSPITAL						PAYMASTER		GLASS MANUF.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		MONT.		OLNEY				18229 DARNELL DRIVE 20832			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
ANTHONY - SANSONE				JULIE - SAFANARA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS			
NO				206-09-0335		HELENA SANSONE		SAME AS # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>										<u>immediate</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/2</u> , 19 <u>86</u> , to <u>5/2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
<u>Dennis Friedman</u>		<u>MD</u>						<u>5/2/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
<u>Dennis Friedman</u>		<u>13-15 East Rega Park Dr. Catonsville</u>									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
REMOVAL (BURIAL)		MAY 4, 1986		SYLVAN HEIGHTS		UNIONTOWN FAYETTE PENN.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						MAY 6 1986		<u>[Signature]</u>			

27.57.1-20

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00-06032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the attending physician or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86
REG. NO.

15017

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARMEN R SANTISO		2a. DATE OF DEATH MONTH DAY YEAR 05 03 86		2b. HOUR 13 ⁰⁰ M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 11 27 02	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN	7b. CITIZEN OF WHAT COUNTRY? SPAIN	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MANUEL RADULFE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA VAZQUEZ		13e. STREET ADDRESS / ZIP CODE 1400 FENWICK LANE 20910	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-64-1258	17. INFORMATION DAUGHTER POTOMAC, MD. 20854 EUGENIA S. CONTRERAS 11705 SMOKETREE ROAD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PANCREATIC CANCER METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 8 MONTH AGO
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>84</u> , to <u>May</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE JAQUINOS	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED May 3, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAQUINOS MD	22e. ADDRESS 5400 Wisconsin Ave Chevy Chase MD 20815		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 6, 1986	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR MAY 8 1986	
25b. REGISTRAR'S SIGNATURE Julia E. Collins			
25c. ADDRESS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.			

00-05815

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, air removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B2
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

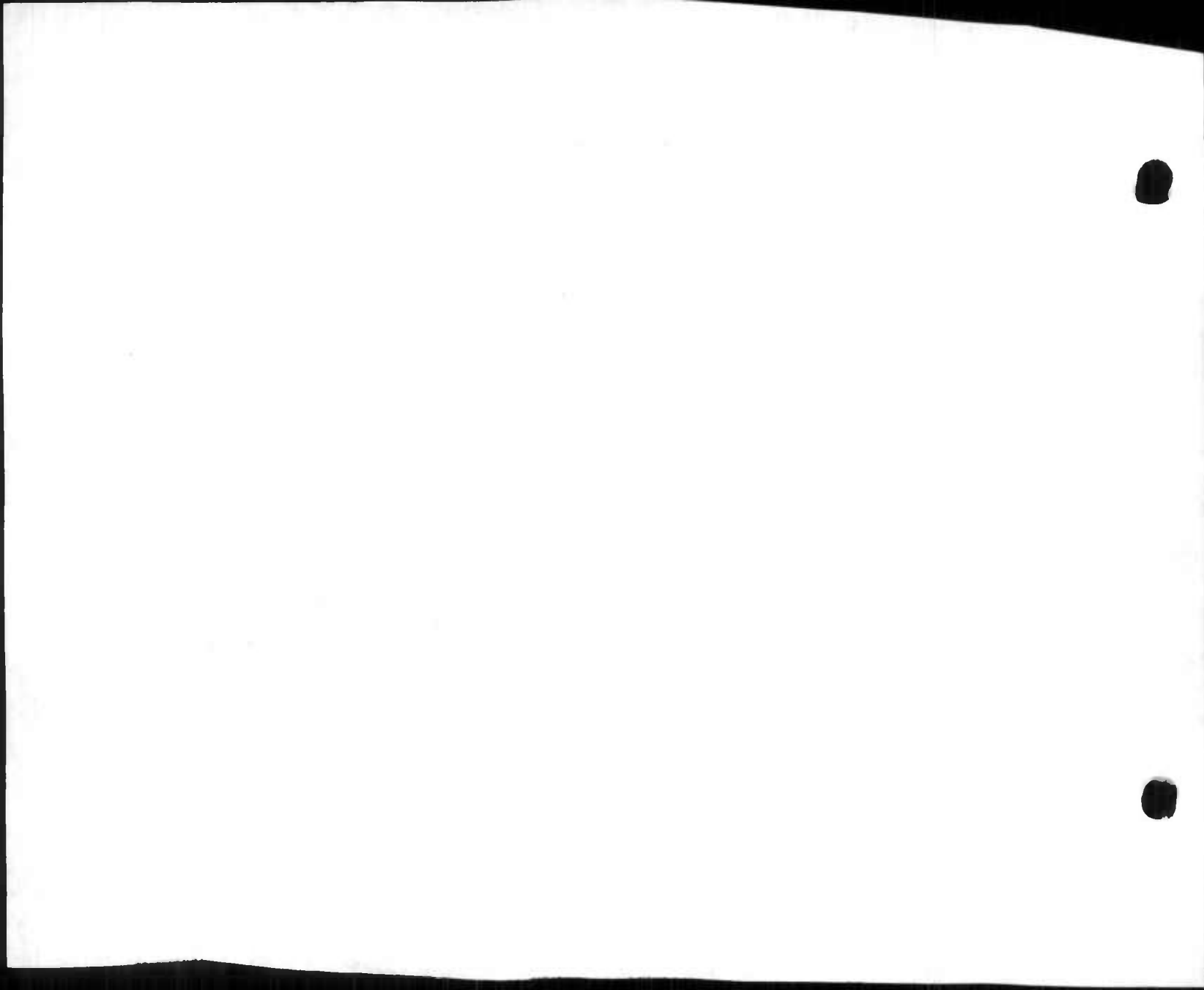
REG. NO.

15018

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY GOODWIN SAXON			2a. DATE OF DEATH MONTH DAY YEAR MAY 2, 1986		2b. HOUR 1100 A
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR July 3 1933	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Randolph Goodwin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dowdy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 249-56-5820		17. INFORMANT Margaret G. Saxon-sister- Potomac, Md. 20854	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive acute intracerebral cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Post. intra cranial aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) hypertension with hyperostotic cardiovascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 26 87 to May 2 86 , that (I) (we) lost saw the deceased alive on May 2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruben E. Cosca		DEGREE		22c. DATE SIGNED 5-2-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN E. COSCA, MD		22e. ADDRESS 1254 REDWOOD ROAD DERWOOD, MD, 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave., ADDRESS Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 6 1986	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

VOID

CERTIFICATE # 86-15019



00-09336

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15020
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL SCHARPET			2a. DATE OF DEATH MONTH DAY YEAR 5 31 86			2b. HOUR 614 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADV. HCLC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY OR TOWN 13b. COUNTY 13c. CITY OR TOWN Maryland Pr Geo Ritchie									

14. FATHER'S NAME FIRST MIDDLE LAST David Baxter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 169 22 8404		17. INFORMANT ADDRESS Lothian Maryland Marvin E Schappert 79 Boones Estate	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) Pulmonary edema underlying cause last Chronic obstructive pulmonary disease (c) 3 days long years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 75 to date , that (I) (we) last saw the deceased alive on 5/30/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.			

22b. SIGNATURE Thos G. WARD	22c. DATE SIGNED 5/31/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD	22e. ADDRESS 6116 Rockwood, Bethesda 20817

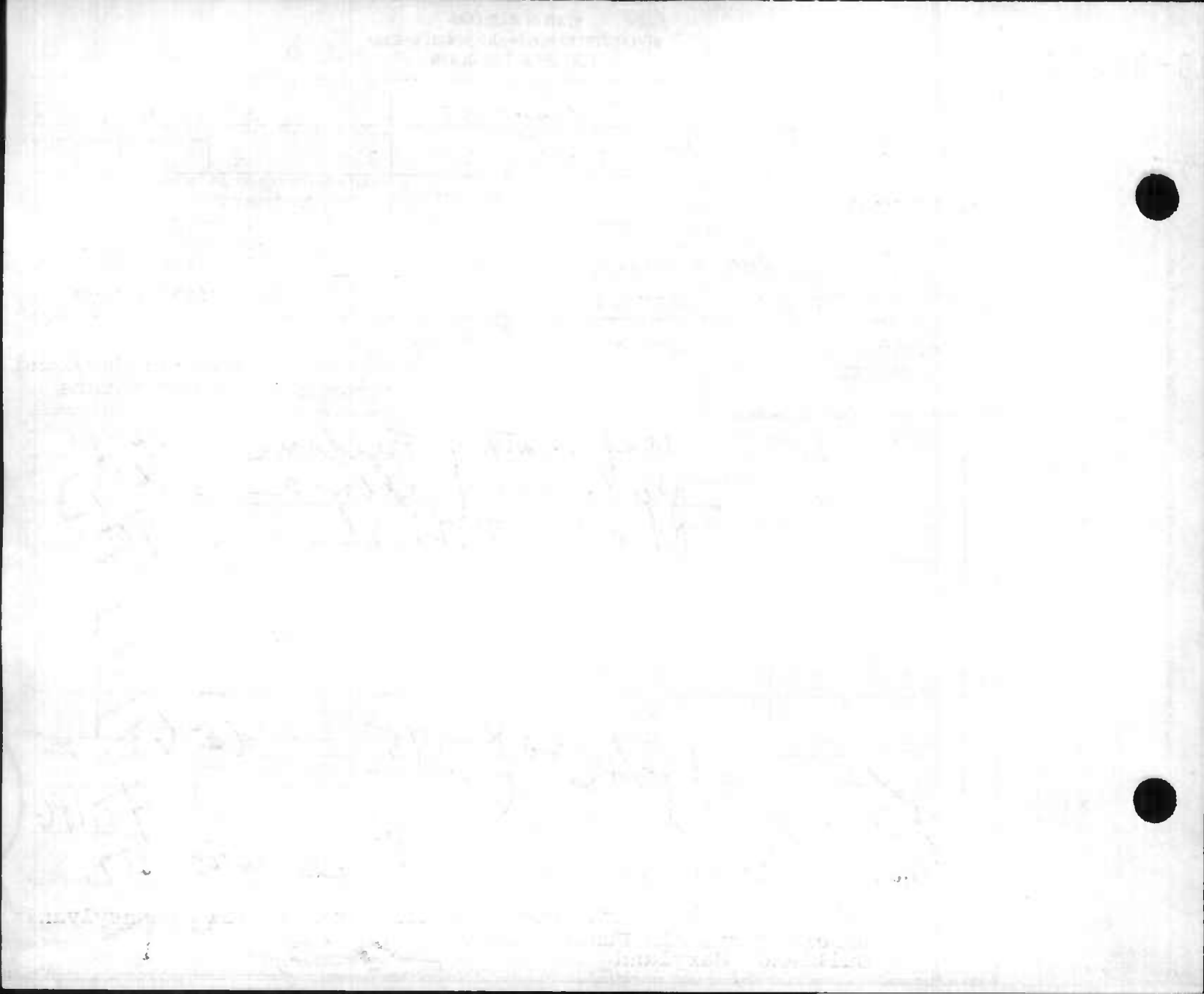
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3 June 1986	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Drexel Hill Pennsylvania
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24. FUNERAL DIRECTOR NAME Robert E Wilhelm	24b. ADDRESS Suitland Maryland	24c. DATE Jun 06 1986	24d. REGISTRAR'S SIGNATURE John Davidson-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



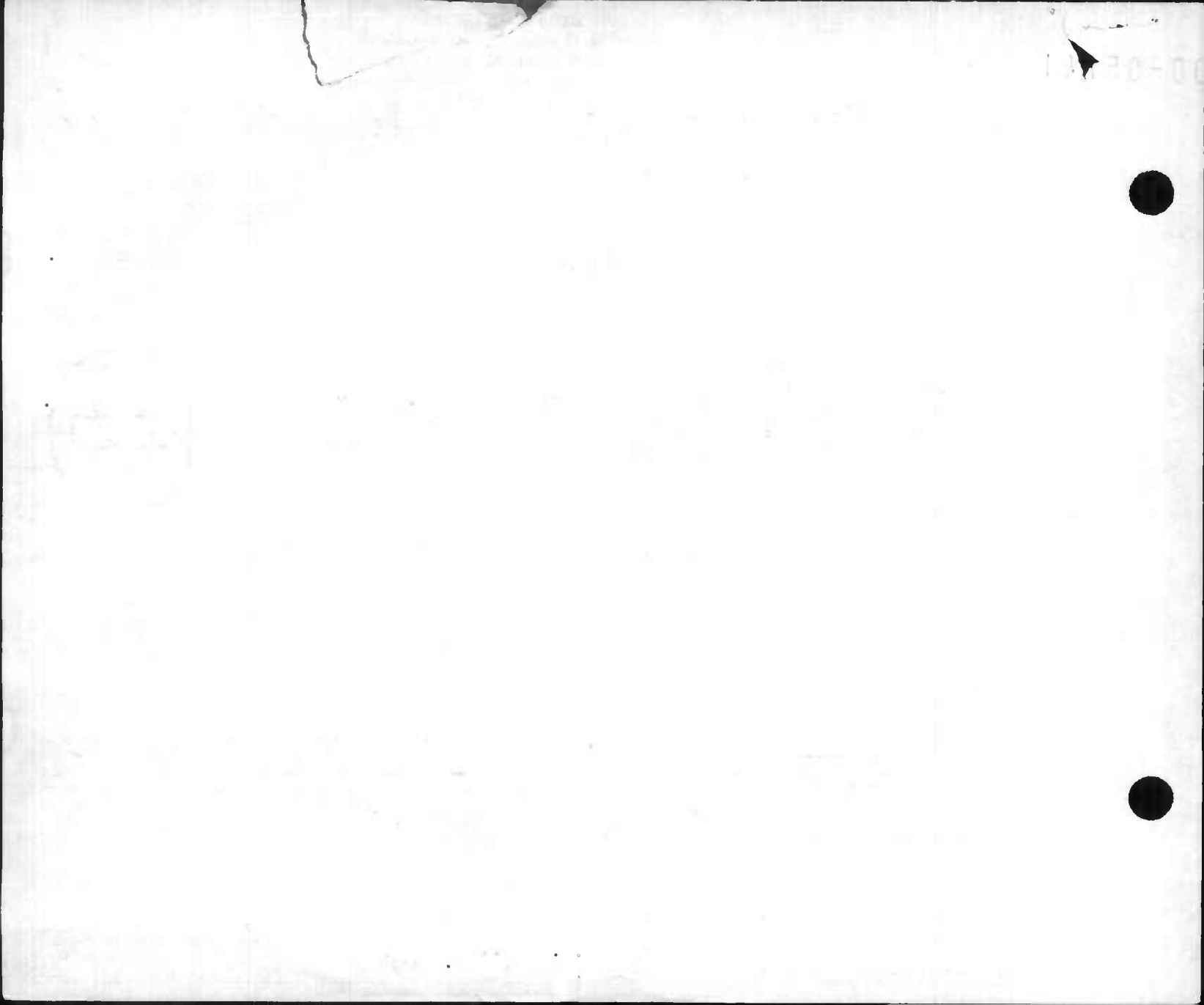
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8/6 15021 REG NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE L. SCHMIDT		2a DATE OF DEATH MONTH DAY YEAR 5-3-86		2b HOUR 6:15 P.M.	
3 SEX F	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home Secretarial		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Federal Reserve Bd.		12b KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY Montgomery S.S.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles A. Schmidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise M. Kraft		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	
16b. SOCIAL SECURITY NO. 577-60-4590		17. INFORMANT ADDRESS 908 Winhall Way Silver Spring, Md.			
18 CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 82</u> to <u>May 3 86</u> that (I) <u>did</u> <u>saw</u> the deceased alive on <u>May 3</u> 19 <u>86</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.					
22b. SIGNATURE THOMAS E. O'DOLE, MD		DEGREE MD		22c. DATE SIGNED May 4, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. O'DOLE, MD		22e. ADDRESS 17904 GEORGIA AVE DUNWOODY, MARYLAND 20831			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 5-7-1986		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15022
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		5 31 86		9:40P M	
ROBERT ELLIS SCHMITT							
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
male		white		3 MONTH 20 DAY 25 YEAR		61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Illinois		USA				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hospital		writer			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		PR. GEO.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
EUGENE SCHMITT		GERTRUDE MEMHARDT		YES		131 18 3541	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
JOAN E. SCHMITT WIFE		SAME AS 13		DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u>			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 28 1986</u> to <u>May 28 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Mark O. Weltz</u>		22c. DATE SIGNED <u>6-1-86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Weltz</u>		22e. ADDRESS <u>7525 Greenway Circle Omie Greenbelt MD 20776</u>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>JUNE 2, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN CREMATORY ALEXANDRIA</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>VIRGINIA</u>	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS, JR.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 4 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial transit permit. These please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 there's any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared per Dr. [illegible]

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-01-01 BY 60322

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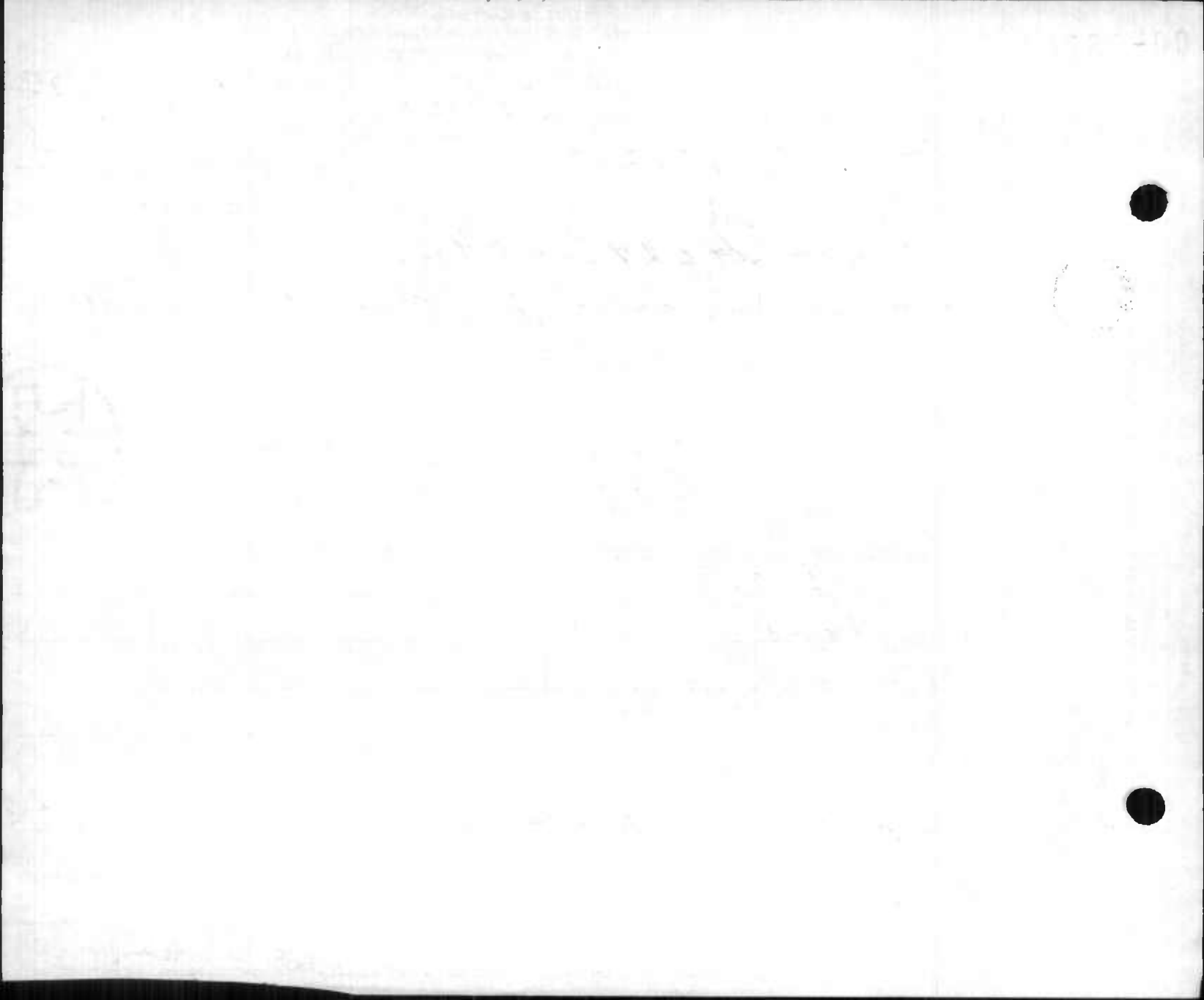
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00-06340

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15023			
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI-MATED DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS MARGARET SCHOCK Davis Schock										2c. DATE PRONOUNCED DEAD		2d. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		13f. CITY OR TOWN			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WARREN BUCK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SNOW JONES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 303-22-9035		17. INFORMANT ADDRESS ROGER L. SCHOCK, HUSBAND, SAME AS ITEM 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>[Signature]</u>				TITLE (SPECIFY) M.D. <u>Regen</u>				MEDICAL EXAMINER		DATE SIGNED <u>May 6 1986</u>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/12/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY ARLINGTON, VIRGINIA STATE					
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009						25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



0-05615

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

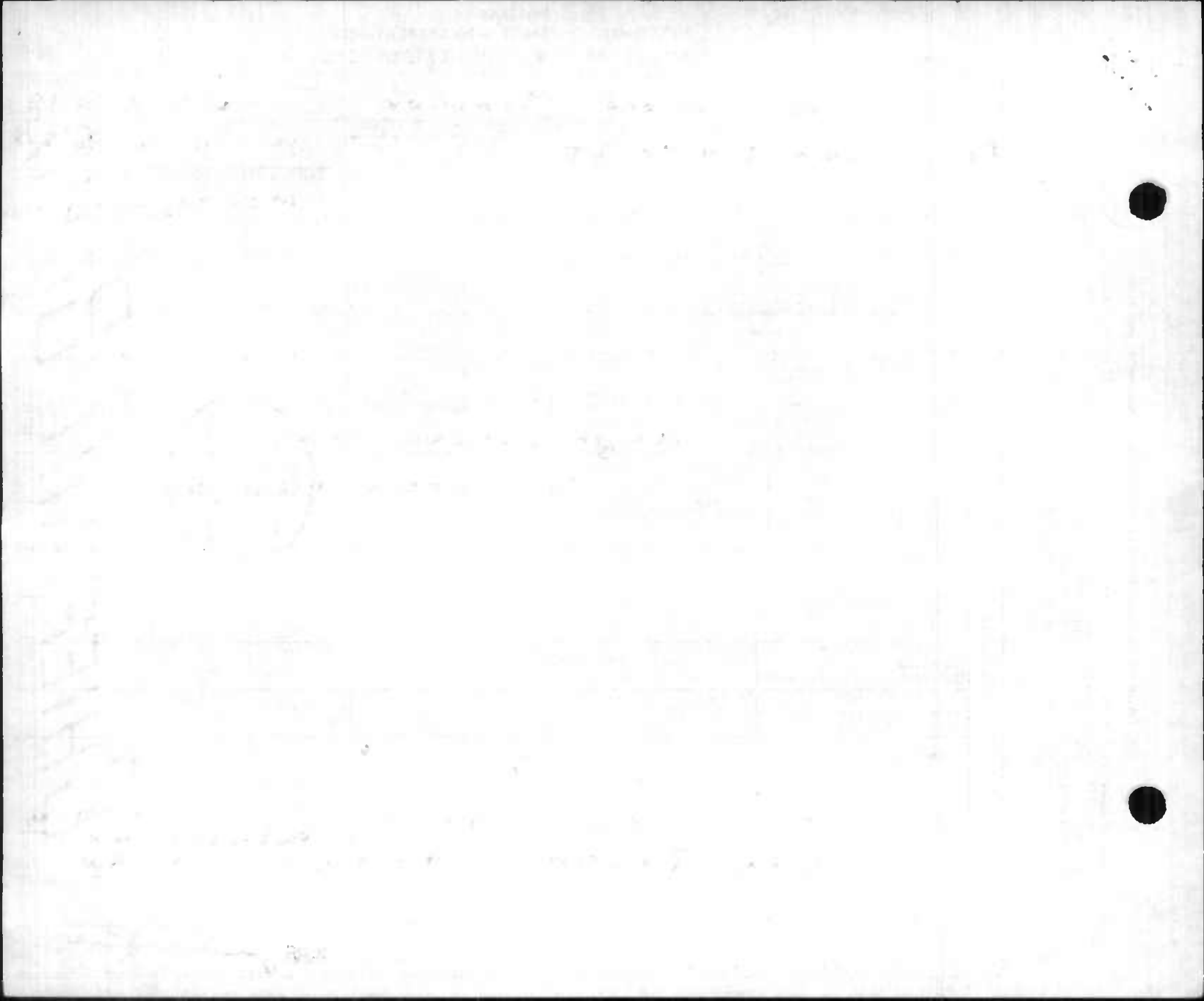
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15024

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
JUNE arlene Schwenk		5 3 19 86		8 18 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	9 4 30	55 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania	United States	WIDOWED	DIVORCED	Montgomery MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	6709 Brigadoon Drive	Homemaker	Own Home		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Bethesda	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6709 Brigadoon Drive/20817	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
David M. Jones			Mary M. Kreisher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		165-24-4917		Francis C. Schwenk, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) asphyxiation due					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. to carbon monoxide.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John Tauber		M.D. Deputy		5-4-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		MEDICAL EXAMINER	
John Tauber		8218 Wisconsin Ave		Bethesda MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		May 5, 1986		Metropolitan Crem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes		MAY 5 1986		www.wisconsin-ave	
7557 Wisconsin Ave. Bethesda, MD 20814 PA					

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BP
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(VR A15 ME (5))



00-06598

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1a. DECEASED NAME (TYPE OR PRINT) RUTH W. SCRIVENS					2a. DATE OF DEATH MONTH DAY YEAR May 12, 1986		2b. HOUR 10:00 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3813 INGLESIDE ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL BOARD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN OLNEY 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 3813 INGLESIDE ST. 20832									
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT C. WILDASIN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - MOORE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 204-03-7880		17. INFORMANT ADDRESS BENJAMIN J. SCRIVENS SAME AS # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mixed Mesodermal Sarcoma of Uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 5/10</u> , 19 <u>86</u> , to <u>5/12</u> , 19 <u>86</u> , that (I) <u>last</u> saw the deceased alive on <u>5/10</u> , 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>personally</u> (did not) view the body after death.									
22b. SIGNATURE <u>G. L. Gold</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/13/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. L. GOLD						22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20900			
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE MAY 15, 1986		23c. NAME OF CEMETERY OR CREMATORY RESTHAVEN MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK FREDERICK MD.		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

10:01

NO

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0-07347

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8615026
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY Ann SCROGGINS			2a. DATE OF DEATH MONTH DAY YEAR 5/21/86		2b. HOUR 9:55 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1934		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Malik		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kollet		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 307-34-8761		17. INFORMANT ADDRESS Ronald M. Scroggins, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 24 hrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hemorrhage 24 hrs DUE TO, OR AS A CONSEQUENCE OF (c) Thrombocytopenia from Hemodilution 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21a. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 15 April 1986 to 21 May 1986 and that (2) my (our) opinion death occurred on the date and hour and from the causes stated above (1) (2) (did not notify the body after death)					
23a. SIGNATURE Thomas A. Bensinger MD		23b. DEGREE MD		23c. DATE SIGNED 5/21/86	
24. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger		25. ADDRESS 7525 Greenway Cir Dr. Greenbelt MD 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE May 27, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Catherine's Cem. Algonac, Michigan	
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey		25. ADDRESS 300 West Montgomery Ave. Rockville, MD		26. DATE REC'D. BY REGISTRAR MAY 22 1986	
27. REGISTRAR'S SIGNATURE		28. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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00-07535

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 5 0 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward (N.M.I.) Seibert			2a. DATE OF DEATH MONTH DAY YEAR May 15, 1986		2b. HOUR 4:30A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 21, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Gas Station
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Guntz		16. STREET ADDRESS / ZIP CODE 6516 Medwick Drive 20783	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 205-16-1356		17. INFORMANT Neoma V. Seibert	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) mitral stenosis		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH GIVEN IN PART 1. Hypokalemia, purpura, Digitalis intoxication			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 5.15.86			
22b. SIGNATURE M Snow MD		22c. DATE SIGNED 5.15.86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD	
22e. ADDRESS 9013 Flower Ave Silver Spring Md 20981		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE May 17, 1986		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE <i>John K. ...</i>	

BP

00-07581

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hazel I. Shaff</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>May 12, 1986</i>			2b. HOUR <i>8:20 AM</i>		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>FEB. 13, 1983</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 83 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		
13a. STATE MARYLAND					13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL S. SHAFF					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LETTIE -- REMSBERG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 214-10-3696		17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD - NLH-ROCKVILLE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia, CVA, AFib.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>UOI bleed.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5/12</i> <i>5/10</i> <i>5/11</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Electrolyte disturbance, stress, renal insufficiency</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/10</i> , 19 <i>86</i> , to <i>5/12</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5/12</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN			22c. DATE SIGNED <i>5/12/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Aschroenboon</i>					22e. ADDRESS <i>18111 Prince Philip Dr md 20832</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/15/1986		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK, MARYLAND				
24. FUNERAL DIRECTOR NAME HYSONG CO., INC.					25a. DATE REC'D. BY REGISTRAR <i>May 22 1986</i>					
25b. ADDRESS 1300-N ST., NW WASH.					25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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(1)

00-06655

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 15029

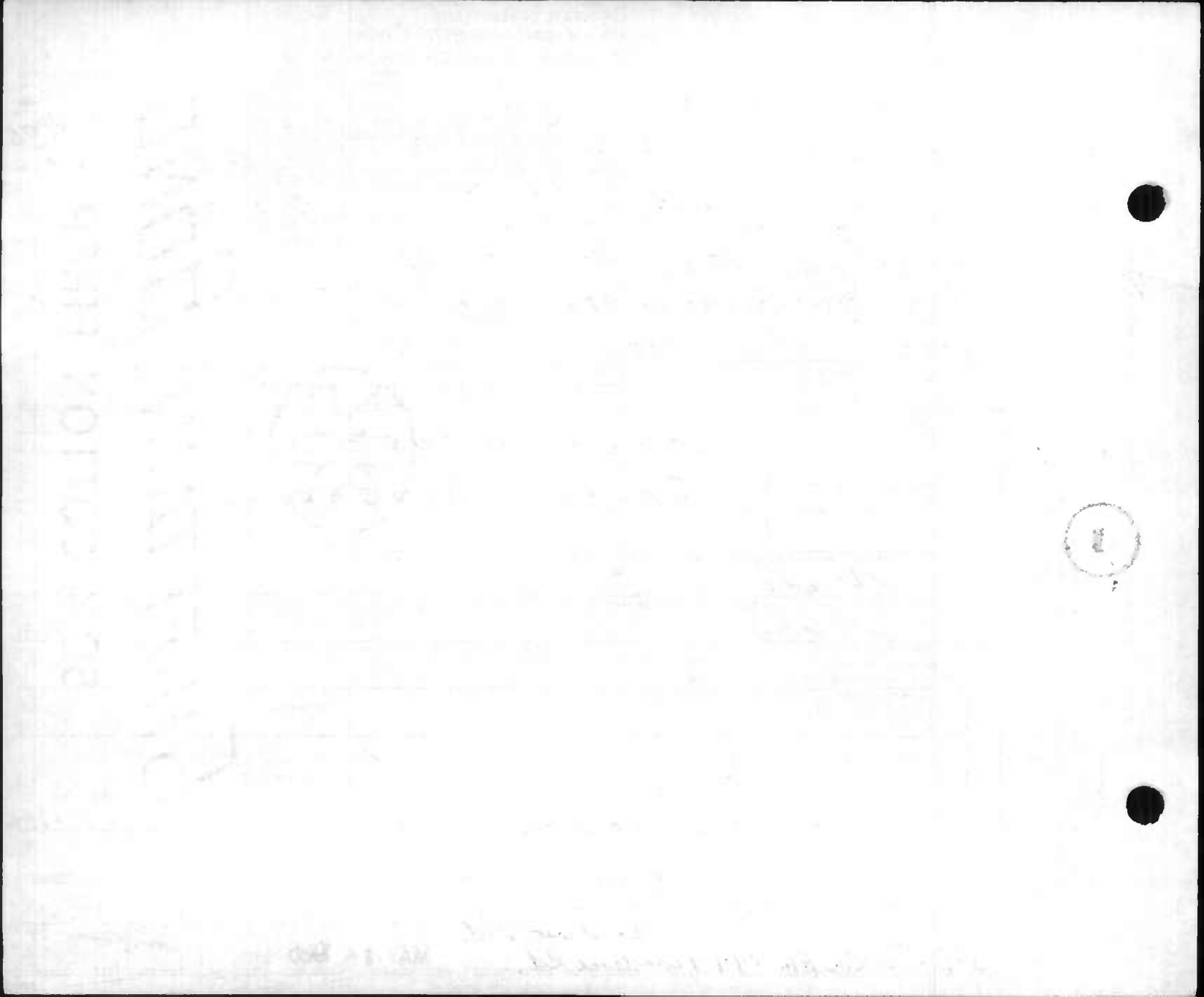
1. DECEASED NAME (TYPE OR PRINT) Amos L. Shaw										2a. DATE KNOWN OF DEATH ESTI-MATED May 12, 1986		2b. HOUR 8:30 P.M.			
3. SEX M		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 7 20 25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD May 12, 1986		2d. HOUR 8:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Si L. Sp...				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK				12b. KIND OF BUSINESS OR INDUSTRY UNK			
13a. STATE MD				13b. COUNTY Prince George's Dist				13c. CITY OR TOWN Golden Leaf				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 505 Golden Leaf Dr. 20743			
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS SHAW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA LEE BRYANT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 248-30-2495				17. INFORMANT FLOSSIE SHAW, 505 GOLDEN LEAF AVENUE, CAPITOL HEIGHTS, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None															
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John St. Jones				TITLE (SPECIFY) Dep. MEDICAL EXAMINER				DATE SIGNED May 12, 1986							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/17/86		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G. MD.					
24. FUNERAL DIRECTOR NAME J.B. Jenkins F.H. ADDRESS 7494 Landover Rd.				25a. DATE REC'D. BY REGISTRAR MAY 15 1986 25b. REGISTRAR'S SIGNATURE Jane Davidson											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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00-08202

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15030

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lenore Shiflett			2a. DATE OF DEATH MONTH DAY YEAR May 30, 1986		2b. HOUR 3:20p m		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1898		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 88	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 721 Mapleton Road/20850		14 FATHER'S NAME FIRST MIDDLE LAST not available Westfall		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iva not available		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 218-20-1723		17 INFORMANT Betty Lee Phillips, same as #13		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) the hospital attended the deceased from 25 April 1986 to 30 May 1986 that (I) we lost saw the deceased alive on 29 May 1986 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.							
22b SIGNATURE WALTER GOOZEH MD		DEGREE MD		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c DATE SIGNED 30 May 86	
23a PHYSICIAN'S NAME (TYPE OR PRINT) WALTER GOOZEH MD		23b ADDRESS 8309 SHOREFIELD ROAD WHEATON MD 20902					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE June 2, 1986		23c NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Funeral Homes		25a DATE REC'D. BY REGISTRAR JUN 2 1986		25b REGISTRAR'S SIGNATURE [Signature]	
7557 Wisconsin Ave. Bethesda, MD 20814							

100-100-002

100-100-002

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00-08528

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove attachments. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

15031

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Norma C. Showalter			2a. DATE OF DEATH MONTH 5 DAY 18 YEAR 86			2b. HOUR 2:00P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Feb. DAY 11 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS. HOURS MIN. 	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Uniroyal			
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 92 Oaklee Village 21229	
14. FATHER'S NAME FIRST Tracy MIDDLE LAST Showalter				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST McLaughlin				16. ADDRESS Md. 20705			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212-10-4520		17. INFORMANT Janet Doetsch ADDRESS 10429 43rd Ave. Beltsville, Md. 20705					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) arteriosclerotic Cardiovascular disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-19 , 19 81 , to 5-18 , 19 86 , that (I) (we) last saw the deceased alive on 5-17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold F. McCann, MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-19-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold F. McCann						22e. ADDRESS 4362-26th St N. McCann 4362-26th St N. Arlington, Va 22207					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery			23d. LOCATION CITY OR TOWN Harrisonburg COUNTY Virginia STATE 			
24. FUNERAL DIRECTOR NAME Hysong Company, Inc. ADDRESS 1300 N Street, NW, Washington, DC 20005						25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE Julia T. ...			

BP

00-06438

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

15032

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Kathryn B. Silverwood</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5 7 86</i>			2b. HOUR <i>9:25 AM</i>	
1. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 27 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>89</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Cuthersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wilson Health Care Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Hales</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Kathryn Harmon</i>		16. STREET ADDRESS / ZIP CODE <i>unknown</i>		17. DDDDD	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-26496</i>		17. INFORMANT NAME ADDRESS <i>Carelyn Kirschen 4004 664 Longwood Southport A.C. 21441</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from <i>Oct 75</i> to <i>5/7/86</i> that (1) (we) last saw the deceased alive on <i>5/7/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <i>Thos G. Ward</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>5/7/86</i>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward</i>		22g. ADDRESS <i>6116 Robinwood, Bethesda 20817</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/9/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Balt. Md.</i>	
24. FUNERAL DIRECTOR <i>Robert Sandison</i>		316 E. Diamond Ave		25a. DATE REGD. BY REGISTRAR <i>MAY 2 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	
Gartner Sandison F.H. Gaithersburg, Md. 20877							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-06661

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86
REG. NO.

15033

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		5/10/86		2-10.4 M	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		MONTH DAY YEAR	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
WEST VIRGINIA		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
SILVER SPRING		ALTHEA WOODLAND NURSING HOME		SUPERVISOR	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. STREET ADDRESS / ZIP CODE	
A.E.C.		3316 GUMWOOD DRIVE 20783		3316 GUMWOOD DRIVE 20783	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		PR. GEO.		HYATTSVILLE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT ADDRESS	
THOMAS WILLIAMS ROBEY		MARY ELLEN KEFFER		MRS. PATRICIA R. FELLERS SAME AS # 13	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19. SOCIAL SECURITY NO.		20. DATE OF OPERATION	
NO		578-32-6308		1980	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>CACHEXIA</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY TUMOR</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPERTENSION, ARTERIO-SCLEROTIC VASC. DISEASE</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED (WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (this hospital) attended the deceased from <u>April 2</u> 19 <u>80</u> to <u>May 10</u> 19 <u>86</u> , that (we) lost saw the deceased alive on <u>May 10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE		22b. DATE SIGNED	
BERNARD A. FITZGERALD MD		5-10-86		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
BERNARD A. FITZGERALD		217 UNIVERSITY BLVD EXT, SILVER SPRING, MD		5-10-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MAY 12, 1986		LIONS CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
WALLACE HARRISON WEST VA.		MAY 15 1986		Francis J. Collins, Jr.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. ADDRESS	
FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.		500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.	

10017-00



00-07853

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15034

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD			2d. HOUR		
SEAN			B. SLOANE			5-17-86			5-17-86			9:50					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR			7. IF UNDER 24 HRS.		
MALE			BLACK			APRIL 1 1986			1 YRS. 16			MONTHS DAYS HOURS MIN.					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9. CITIZEN OF WHAT COUNTRY?			10. MARRIED			10. NEVER MARRIED			10. WIDOWED			10. DIVORCED		
MARYLAND			U.S.A.			XX											
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			14. KIND OF BUSINESS OR INDUSTRY								
Silver Spring			Holy Cross Hospital			NONE											
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			16. CITY OR TOWN			17. INSIDE CITY LIMITS?			18. STREET ADDRESS								
MD.			MONTGOMERY			SILVER SPRING			YES X NO			2024 SANDSTONE CT.			20904		
19. FATHER'S NAME			20. MOTHER'S MAIDEN NAME			21. WAS DECEASED EVER IN U.S. ARMED FORCES?			22. SOCIAL SECURITY NO.			23. INFORMANT			24. ADDRESS		
WALTER			CAROL			NO			NONE			WALTER SLOANE			2024 SANDSTONE CT S.S. MD.		
25. PART I DEATH WAS CAUSED BY:			26. IMMEDIATE CAUSE (a)			27. DUE TO, OR AS A CONSEQUENCE OF			28. (b)			29. DUE TO, OR AS A CONSEQUENCE OF			30. (c)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I DEATH WAS CAUSED BY:			sudden infant death syndrome											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
31. DATE OF OPERATION			32. CONDITION FOR WHICH OPERATION WAS PERFORMED?			33. AUTOPSY?			34. YES			34. NO					
35. EXTERNAL CAUSE WAS			36. TIME OF INJURY			37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			P.M. 19														
38. INJURY OCCURRED			39. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			40. LOCATION			CITY OR TOWN			COUNTY			STATE		
WHILE AT WORK NOT WHILE AT WORK																	
41. I certify that I took charge of the remains described above, held on			Autopsy X			Inspection			Inquiry			and in my opinion					
death resulted from:			Natural causes X			Accident			Suicide			Homicide			Undetermined manner		
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED											
Margarita A. Korell, M.D.			Assistant MEDICAL EXAMINER			5-18-86											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS														
111 Penn Street																	
42. BURIAL, CREMATION, REMOVAL (SPECIFY)			43. DATE			44. NAME OF CEMETERY OR CREMATORY			45. LOCATION			CITY OR TOWN			COUNTY		
BURIAL			5-21-1986			ROCK CREEK CEMETERY			WASHINGTON, D.C.								
46. FUNERAL DIRECTOR			47. DATE REC'D BY REGISTRAR			48. REGISTRAR'S SIGNATURE											
JOHNSON & JENKINS			716 KENNEDY ST. N.W. WASH			MAY 28 1986											

DIVISION OF VITAL RECORDS, 201 W. PESTONKY ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3-RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PESTONKY STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



33

12

Q

10

11

12

13

14

06-08490

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15035

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) DOROTHY EDITH SMITH			2a DATE OF DEATH MONTH DAY YEAR MAY 29, 1986		2b HOUR 9:20 PM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR NOVEMBER 21, 1919		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH SILVER SPRING	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3624 PEAR TREE COURT #13		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MANAGER	12b KIND OF BUSINESS OR INDUSTRY BANK	

13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3624 PEAR TREE CT. #13 20906	
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14 FATHER'S NAME FIRST MIDDLE LAST ROY MILLER SMITH	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZORA AMANDA WATKINS
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16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b SOCIAL SECURITY NO. 129-07-5601	17 INFORMANT HELEN KNUDSEN, SISTER, 4204 HEATHFIELD RD.	ADDRESS ROCKVILLE, MD. 20853
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>		<u>3 months</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of G.I. Tract</u>		<u>6 months</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>	
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19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from <u>May 15, 1986</u> to <u>May 29, 1986</u> , that (I) (we) last saw the deceased alive on <u>May 29, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
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22b SIGNATURE <u>Eugene P. Libee</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>30 May 86</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eugene P. Libee MD</u>		22e ADDRESS <u>10410 Cornwell Rd Kensington MD 20885</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 5/31/86	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD.
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24 FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009	25a DATE REC'D. BY REGISTRAR JUN 4 1986	25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>
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DATE: 10/10/68

TIME: 10:00 AM

FROM: [illegible]

TO: [illegible]

RE: [illegible]

DATE: 10/10/68

TIME: 10:00 AM

FROM: [illegible]

TO: [illegible]

RE: [illegible]

DATE: 10/10/68

TIME: 10:00 AM

FROM: [illegible]

TO: [illegible]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15036

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR					
Helen E. Smith								May 14 1986											
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
F	B	Jan 4 11 75		YRS.		MONTHS		DAYS		May 14 1986									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
VIRGINIA		USA										Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY													
S. Y. Spg. H. & Cross Hosp		(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		HOUSEWIFE		HOME													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MD		Mont		Scripps		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2302 Greenway Lane											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
BEN				SMITH, SR.		AMY				SMITH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		13609 CREEKSIDE DRIVE SILVER													
NO		578-28-7675		MRS. CHARLOTTE BELLAMY		SPRING, MD.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
<u>None</u>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED							
<u>John S. D. Egan</u>				M.D. <u>Dop</u>								May 14 1986							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				5/ 23/86				MT. HOPE BAPT CH CEM				FREDERICKSBURG VIRGINIA							
24. FUNERAL DIRECTOR				NAME				ADDRESS				DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
MARSHALL'S FUNERAL HOME				WASH, D.C.				4217 9TH ST. N.				MAY 16 1986				<u>John S. D. Egan</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSFER, OR CREMATION RECORD. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



07-823

TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8615037 REG. NO.			
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) <u>INEZ</u> <u>K.K.</u> <u>SMITH</u> <u>SMITH</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>5/27/1986</u>		2b. HOUR <u>10AM</u> M	
3. SEX <u>Female</u>			4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Aug.</u> <u>13</u> <u>1904</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Iowa</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.				
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HALL CHASE HOSPITAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Registered Nurse</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>San Fran., CA</u>				
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1221 Devere Drive</u> <u>20903</u>				
14. FATHER'S NAME FIRST MIDDLE LAST <u>James</u> <u>Kent</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Coral</u> <u>Bascom</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>N/A</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>N/A</u>		17. INFORMANT ADDRESS <u>A Marie Grismore-daughter-(same as 13e)</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 YEARS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>28 APRIL</u> <u>19</u> <u>86</u> <u>19</u> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>2309 Shorefield Rd Wheaton Md</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>28 APRIL</u> <u>19</u> <u>86</u> , to <u>27 May</u> <u>19</u> <u>86</u> , that (I) (we) last saw the deceased alive on <u>26 May</u> <u>19</u> <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Walter E. Goetz MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>27 May 86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER E. GOETZ MD</u>					22e. ADDRESS <u>2309 Shorefield Rd Wheaton Md</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>5-31-1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR NAME ADDRESS <u>Hines/Rinaldi Funeral Home</u> <u>11800 N.H. Ave.,</u> <u>Silver Spring, Md.</u>					25a. DATE REC'D. BY REGISTRAR <u>MAY 28 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

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00-08328

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15038

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Julius			V.			Soloku			5-24			1986			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male		Black		July 18 1938		47		MONTHS DAYS		HOURS MIN		5-25		7:41	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Sierra Leone				Diplomatic Visa								Montgomery County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				15 Manchester Place, #303				Information Attache				Sierra Leone			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Montgomery				Silver Spring				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
Samuel				Titi				N/A				N/A			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
Samuel Tucker				Hypertensive Arteriosclerotic Cardiovascular Disease											
17. INFORMANT ADDRESS				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
17106 Camellia Dr.				Intestinal Infarct											
Silver Spring, Md.															
220906															
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from				22b. TIME OF INJURY				22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR				P.M. 19							
22d. INJURY OCCURRED				22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				22f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Dennis F. Smyth, M.D.				Assistant				5-25-86							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201				Removal				June 9, 1986			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Hines/Rinaldi Funeral Home				JUN 3 1986											
11800 New Hampshire Ave.															
Silver Spring, Md.															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGIN. WITH FORM "PM" 3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

8

FOR
STATE
REGISTRAR

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

B

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medicolegal summer must be noted on page 4 once.

DHMH - 16 60M 7/84
(VRA 15. 4)

907-46-00



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 4 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3. DATE OF BIRTH		4. AGE (IN YEARS LAST BIRTHDAY)	
Albert Russell Stahmann		June 27, 1925		60	
5. SEX		6. RACE		7. DATE OF BIRTH	
Male		White		June 27, 1925	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. BALTIMORE CITY OR COUNTY OF DEATH	
New York		USA		Montgomery County MD.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		NIH, The Clinical Center		Supervisor	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS / ZIP CODE	
17a. STATE		17b. COUNTY		17c. CITY OR TOWN	
Florida		Brevard		Titusville	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. ADDRESS	
Elmer Stahmann		Maude Russell		Same as item #13	
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21b. SOCIAL SECURITY NO.		21c. INFORMANT	
Yes		WWII		Mrs. Virginia Stahmann (Wife)	
22. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		23. IMMEDIATE CAUSE (a)		24. DUE TO, OR AS A CONSEQUENCE OF	
		PNEUMONIA, CARDIAC FAILURE			
		(b) PELVIC ABSCESS, PERFORATION OF ESOPHAGUS			
		(c) GASTRIC CANCER			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
JAUNDICE					
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		25c. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
27a. INJURY OCCURRED		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		27c. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
28. I certify that (this hospital) attended the deceased from August 22, 1984, to May 17, 1986, that (we) lost saw the deceased alive on May 17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
29a. SIGNATURE		29b. DEGREE		29c. DATE SIGNED	
Barbara A. Ward		MD		5/17/86	
30a. PHYSICIAN'S NAME (TYPE OR PRINT)		30b. ADDRESS			
BARBARA A. WARD		National Institutes of Health Clinical Center, Bethesda, Md. 20892			
31a. BURIAL, CREMATION, REMOVAL (SPECIFY)		31b. DATE		31c. NAME OF CEMETERY OR CREMATORY	
Cremation		5/18/86		Metropolitan Crematory	
32a. LOCATION		32b. COUNTY		32c. STATE	
Alexandria, Virginia					
33. FUNERAL DIRECTOR NAME		33b. ADDRESS		33c. DATE REC'D BY REGISTRAR	
Brevard Funeral Home North		1450 Norwood Ave., Titusville, Florida 32796		MAY 20 1986	
34. REGISTRAR'S SIGNATURE		34b. REGISTRAR'S SIGNATURE			
		June Anderson-Pandora			

63150-01



00-06090

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8615041

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MEHRLE E. STALEY SR.		2a. DATE OF DEATH MONTH DAY YEAR 5 7 86		2b. HOUR 1:30 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 6 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Masonry
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY MONT	13c. CITY OR TOWN GAITHERSBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 23630 WOODFIELD ROAD 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Ezra Staley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith A. Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-24-8398		17. INFORMANT Lois S. Armacost, 5428 Arcadia Ave. Upperco, Md. 21155	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Parkinson's disease, long hypertension. Old COA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-6-86 to 7-6-86 , that (I) (we) last saw the deceased alive on 5-6-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruben Cosca		DEGREE M.D.		22c. DATE SIGNED 5-7-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN COSCA, M.D.		22e. ADDRESS 17524 REDLAND ROAD, NEWTOWN, MD, 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet	
23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.		24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.			
25a. DATE REC'D. BY REGISTRAR MAY 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15042

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST DEBORAH ANN STANLEY		2a. DATE KNOWN OF DEATH DATE OF EST. DEATH MATED <input checked="" type="checkbox"/> 5-16-86 MONTH DAY YEAR		2b. HOUR M 6:30P	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4/18/36		6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-16-86	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5480 Wisconsin Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5480 Wisconsin Avenue, 20015	
14. FATHER'S NAME FIRST MIDDLE LAST Carlton R. Stanley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth B. Phineas		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. DECEASED'S ADDRESS Johann F.A. von Franke 5870 Thunderhill Road, 21045	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
		ACTUAL SIGNATURE <u>Margarita A. Korell</u>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5-17-86	
		EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE (SPECIFY) 6/5/86		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Baltimore Co, Md			
24. FUNERAL DIRECTOR NAME JAMES N. KOTSIS F.H.,		ADDRESS 6411 Windsor Mill Rd.		25a. DATE REC'D. BY REGISTRAR JUN 5 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMAL BIRTH RECORD PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP 173
DHMM - 17
(VR A15 ME (5))

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05/11/2015

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Monty o'ryz

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bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted January 1, 2016. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18 per DR. DOMAN		STATE OF MARYLAND	
FOR 7/7/86 DAD		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
1- STATE REGISTRAR		CERTIFICATE OF DEATH	
DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
MAURICE, GALE Staten		5 30 86 4:28 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
m	W	10 10 23	62 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	USA		Montgomery MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross	Service Advisor	Automobile
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
md	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS / ZIP CODE	
Chester Staten	Beulah Jenkins	1314 Diston Rd 20903	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	Daughter Patricia G. Smith	2104 Woodford Road Vienna, Virginia 22180
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Coronary Artery Ruptured Abdominal Aortic Aneurysm			
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lung Disease CARDIOPULMONARY ARREST			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lung Disease			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	HOUR A.M. MONTH DAY YEAR P.M. 19		
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/25/86, 19 86, to 5/30/86, 19 86, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
David B. Donnan M.D.			5/30/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
David B. Donnan M.D.	12012 Veirs Mill Road Wheaton Maryland 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	June 2, 1986	Fort Lincoln Cemetery	Brentwood Pr. Geo. Maryland
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Francis J. Collins, Jr.		JUN 4 1986	
500 University Blvd., W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE	
		Julia Davidson-Randall	

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15044

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) OLIVER W. STEINFORT				2a. DATE OF DEATH MONTH 5 DAY 2 YEAR 86		2b. HOUR 1:15p M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOME) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Comptroller		12b. KIND OF BUSINESS OR INDUSTRY Riggs Nat'l Bank		
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST Henry MIDDLE Steinfort				15. MOTHER'S MAIDEN NAME FIRST Dena MIDDLE DeVries LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT ADDRESS Gazelle S. Steinfort same as 13c				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung cancer, metastatic to brain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Septic shock, Bilateral pneumonia and pulmonary infarction.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 85 to 2 May 19 86 , that (I) (we) last saw the deceased alive on 2 May 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE Donald E. Dillon				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2 May 86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon				22e. ADDRESS 18111 Prince Philip Dr. Olney, Maryland 20832				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/6/86		23c. NAME OF CEMETERY OR CREMATORY Quantico National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Quantico, Virginia		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR MAY 7 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

10-08912

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner must be notified of at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8615045

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST		5 27 86		1205 M	
Margaret Stevens					
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR	77 YRS.	IF UNDER 24 HRS	
S-5-09					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
SE, USA	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington Adventist Hosp	Homemaker	Own Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
D.C.	N/A	Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1200 42nd Pl., N.E. 99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Lawrence Richardson		Annie (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		579-54-9014		Dorothy M. Johnson-Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b) Ischemic Left cerebral infarct					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Severe Atherosclerotic Cardiovascular Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Aspiration pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 85, to May 27 19 86, that (I) (we) last saw the deceased alive on May 27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
T.S. Locke, III M.D.		MD		5/27/86	
22d. PHYSICIAN'S NAME WITH OFFICE		22e. ADDRESS			
		8580 Second Ave Silver Spring, Md. 20910			
23a. (BURIAL) CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		5/31/86		HARMONY MEM. PARK	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				CUMMEROVER, P.G., MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
H.S. WASHINGTON & SONS 4925 BURROUGHS AVE, W		JUN 09 1986		John Davidson Anderson	

1. Name of the plant
2. Date of collection
3. Locality
4. Collector's name
5. Number of specimens
6. Weight of specimens
7. Description of specimens
8. Remarks

1. Name of the plant
2. Date of collection
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7. Description of specimens
8. Remarks

1. Name of the plant
2. Date of collection
3. Locality
4. Collector's name
5. Number of specimens
6. Weight of specimens
7. Description of specimens
8. Remarks

00-06297

1- FOR
STATE
REGISTRAR

Lettie E. Stewart

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lettie E. Stewart		2a. DATE OF DEATH MONTH DAY YEAR 6/5/86		2b. HOUR 5:05 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 17 1884	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IL		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) English Teacher	
13a. STATE Maryland		13b. CITY OR TOWN SILVER SPRING		13c. STREET ADDRESS / ZIP CODE 6 MIDHURST RD 20910	
4. FATHER'S NAME FIRST MIDDLE LAST Ethelbert R. Stewart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lettie Cox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-4396		17. INFORMANT ADDRESS Anne D. Stewartson Same as item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock due to massive MI DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/5/86 , 19____, to 6/5/86 , 19____, that (I) (we) last saw the deceased alive on 5/5/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Smith Ho, M.D.		DEGREE		22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH Ho, M.D.		22e. ADDRESS 7610 Carroll Ave N.K.P.R. and 8323 Haddon DR. Takoma Park Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/86		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC		23e. DATE REC'D. BY REGISTRAR MAY 09 1986			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC		25. REGISTRAR'S SIGNATURE Lelia Davidson Register			

MEDICAL CERTIFICATION

times of day.

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1

1992

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John L. ...

Season	13sp (%)	14sp (%)
winter	~15	~10
spring	~25	~35
summer	~45	~55
autumn	~65	~55

2

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00-06283

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15047
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED J. STEWART MIDDLE LAST			2a. DATE OF DEATH MONTH 5 DAY 4 YEAR 86 2b. HOUR 1155 P.M.	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH Feb. 2, DAY 2, YEAR 1914	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTG 13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17628 Sequoia DR / 20877
14. FATHER'S NAME FIRST Marshall MIDDLE JOHNSON LAST		15. MOTHER'S MAIDEN NAME FIRST GRACE MIDDLE MASON LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-9660	17. INFORMANT ADDRESS Harlean C. Prather 18920 Germantown Rd. Germantown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>TERMINAL HEART FAILURE, BIVENTRICULAR</u> IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATO RENAL FAILURE</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>OBSTRUCTIVE PULMONARY DISEASE</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>FAILURE TO THRIVE</u>	
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-23</u> 19 <u>86</u> , to <u>5-04</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-03</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>John Suncion</u> MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A SUNCION, HECTOR</u>		22e. ADDRESS <u>18730 Germantown Road, Germantown Md</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-8-86	23c. NAME OF CEMETERY OR CREMATORY Asbury Church Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Germantown, Montg. MD
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24. FUNERAL DIRECTOR NAME George R. Snowden	24b. ADDRESS 246 N. Washington Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>John Suncion</u>
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00-06596

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15048

1. DECEASED NAME (TYPE OR PRINT)			FIRST Aimee			MIDDLE Louise			LAST Stoner			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/9 1986			2b. HOUR M 9:40				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1909		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/9 1986			24. HOUR M A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9904 Markham Street								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer				12b. KIND OF BUSINESS OR INDUSTRY Medical			
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 9904 Markham Street 20901			
14. FATHER'S NAME FIRST MIDDLE LAST George McDonald				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Wilson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-6120				17. INFORMANT ADDRESS Frederick A. Stoner Husband Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																			
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 5/9/86							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Montgomery County, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 13, 1986				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr Geo Maryland							
24. FUNERAL DIRECTOR Francis J. Collins Jr. 500 University Blvd., W. Silver Spring, Md.												25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A FILING WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

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00-06928

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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9

1. DECEASED NAME (TYPE OR PRINT) MARY JEANNE STRAUCH			2a. DATE OF DEATH MONTH DAY YEAR MAY 6 1986		2b. HOUR 11:22^M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 20^{AT} 1926^{EAR}		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN POTOMAC	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11511 DEBORAH DRIVE 20854
FATHER'S NAME FIRST MIDDLE LAST VICTOR E. ERICKSON			MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE GERTRUDE LOWREY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 470-26-2137		17. INFORMANT ADDRESS STEPHEN T. STRAUCH, 11511 DEBORAH DRIVE.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) ADULT RESPIRATORY DISTRESS SYNDROME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CIRRHOSIS OF THE LIVER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 20 , 19 86 , to MAY 6 , 19 86 , that (I) (we) lost saw the deceased alive on MAY 6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED MAY 7 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. EDMUNDS, LCDR, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-12-86	23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Aitkin, Aitkin, Minn.
24. FUNERAL DIRECTOR'S NAME Stronson-Root-Brenny F.H.		25. DATE REC'D. BY REGISTRAR MAY 19 1986	
31. Minnesota Ave, S., Aitkin, Minn 56431			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

00-66030

APR 11 1964

ENCLOSURE

RECEIVED



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8615050

REG. NO.

1- FOR
STATE
REGISTRAR

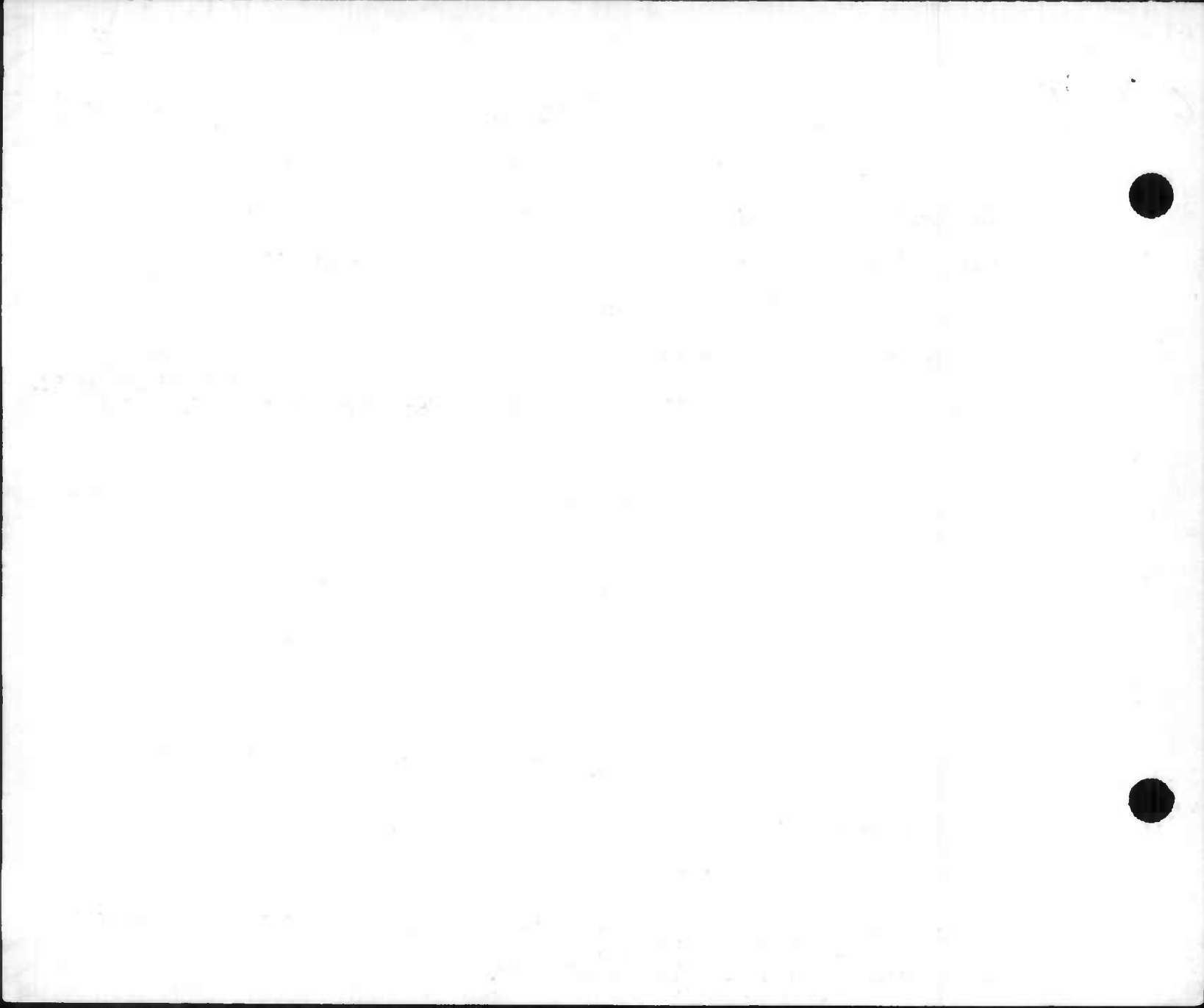
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ab SudRAK			2a. DATE OF DEATH MONTH DAY YEAR 05-29-86		2b. HOUR MIN 9:04 PM						
3. SEX Female		4. RACE ASIAN		5. DATE OF BIRTH MONTH DAY YEAR 01-31-15		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71		7. IF UNDER 1 YEAR MONTHS DAYS 71		8. IF UNDER 54 HRS. HOURS MIN. 9:04 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Thailand		7b. CITIZEN OF WHAT COUNTRY? Thailand		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY mont		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS - ZIP CODE 2310 Dennis Ave 20902			
14. FATHER'S NAME FIRST MIDDLE LAST Manat Saithong				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leane Saithong				ADDRESS 12412 Littleton St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-66-4447		17. INFORMANT Adisak Sudrak Son Wheaton, Md. 20906					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ? 1 hour											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Congestive heart failure, atrial fibrillation, severe chronic obstructive pulmonary disease											
19a. DATE OF OPERATION Aug 29 1986				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Aug 29 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6111 EXECUTIVE BLVD, ROCKVILLE, MD			
22a. I certify that (1) this hospital attended the deceased from Aug 29 1986 to May 29 1986 , that (1) (we) last saw the deceased alive on May 27 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE William H. Silverman				DEGREE MD				22c. DATE SIGNED 5/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. SILVERMAN				22e. ADDRESS 6111 EXECUTIVE BLVD, ROCKVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE May 30 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR JUN 4 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson			
500 University Blvd., W. Silver Spring, Md.											

MEDICAL CERTIFICATION

29

BP

Cleared by Dr. Rogers
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-09173

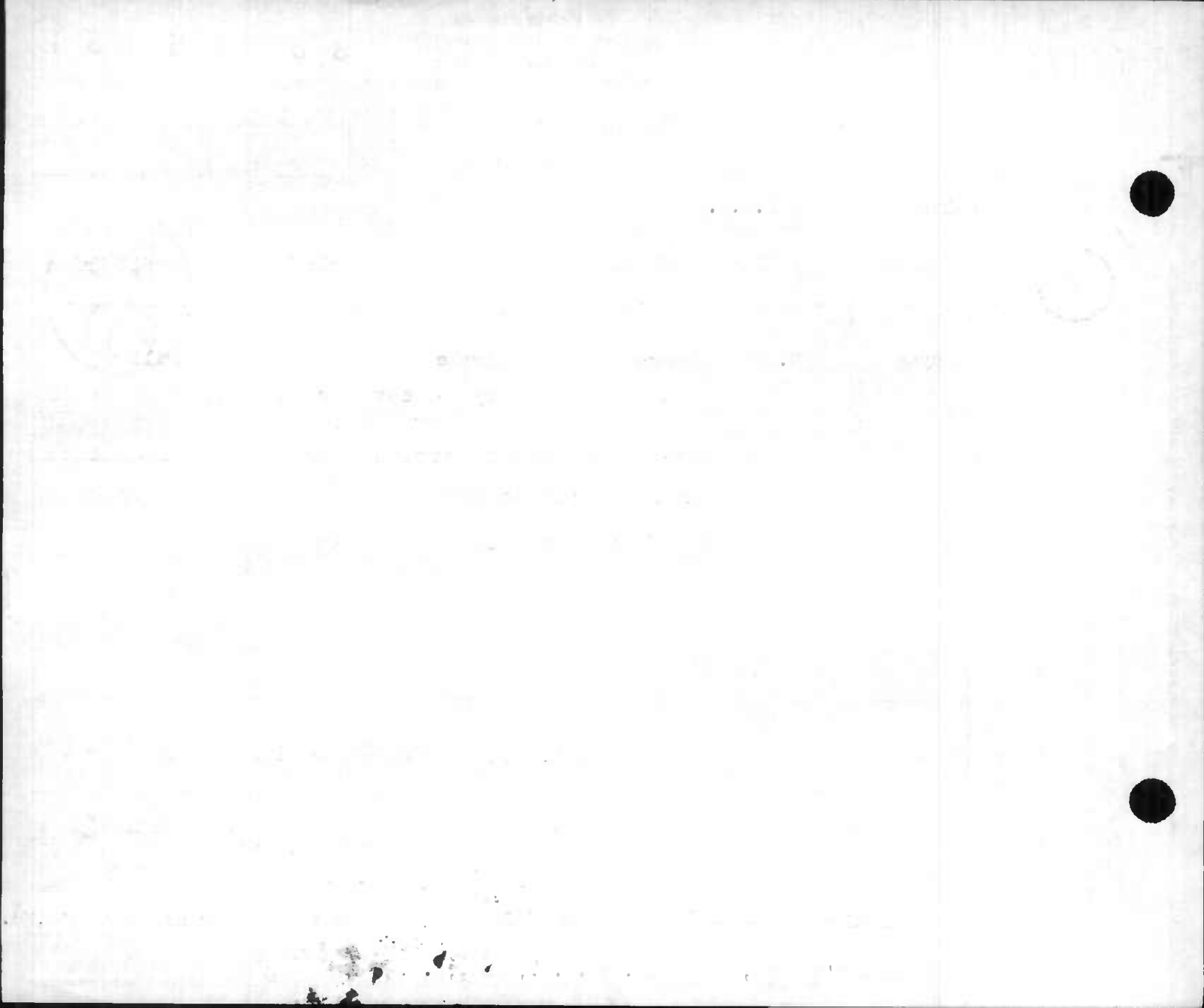
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO. 8615051							
1. DECEASED NAME (TYPE OR PRINT) FIRST MAE MIDDLE ADELE LAST SWANGO				2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1986		2b. HOUR 2:20p M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Credit Union			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5341 RANDOLPH RD. #3 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Wayne H. Swango		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle MacMillan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
		16b. SOCIAL SECURITY NO. 313-24-9954		17. INFORMANT ADDRESS Mary Gunter, power att. same as pt.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Monocytic lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Nodular poorly differentiated lymphoma 5 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 2 weeks 5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 9, 1980, to May 28, 1986, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Francine M. Foss MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/30/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francine M. Foss MD		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-31-86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges's, Md.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons		ADDRESS 5130 Wis. Ave. N.W., Wash. D.C.		25. MARYLAND REGISTRAR'S SIGNATURE John H. ...		26. REGISTRAR'S SIGNATURE John H. ...			

BP



00-07319

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 5 0 5 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earl L. Taisey			2a. DATE OF DEATH MONTH DAY YEAR May 21, 1986		2b. HOUR 8:00a _M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Poolesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18511 Darnestown Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaners
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Clifton Taisey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Belle Mox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-03-0743		17. INFORMANT Linda G. Wallaesa, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1985</u> to <u>MAY 21 1986</u> ; that (I) (we) last saw the deceased alive on <u>MAY 29 1986</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 21, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen M. Hellman, M.D.		22e. ADDRESS 6246 Montrose Road Rockville, Maryland 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 24 1986	23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS 300 West Montgomery Ave. Rockville, MD PA		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

01858-2



0-05983

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15053

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT R. TAPP			2a. DATE OF DEATH MONTH DAY YEAR May 7, 1986		2b. HOUR 6A MM		
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lincoln Nebraska U. S. A.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.	
10. CITY OR TOWN OF DEATH Silver Spring.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 816 Violet Pl. Silver Spring.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Post Office.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland.		13b. COUNTY Montgomery.		13c. CITY OR TOWN Silver Spring.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Tapp.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Harkson.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, AND IN WHAT TOWN) Yes. Navy		16b. SOCIAL SECURITY NO. 215-20-3324	
17. INFORMANT ADDRESS Richard Tapp. Brother (13 e)		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Esophagus DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure - chronic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min			

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from 13 Feb 1986 to 5 May 1986 , that (b) we last saw the deceased alive on 5 May 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)							

22b. SIGNATURE Thomas A. Bensinger		22c. DEGREE MD		22d. DATE SIGNED 5/7/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger		22f. ADDRESS 7525 Greenway Ctr Dr. Greenbelt MD 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE May 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn, Rockville, Montg. Co., Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Co., Md.		23e. DATE REC'D. BY REGISTRAR MAY 8 1986		23f. REGISTRAR'S SIGNATURE John Davidson-Randall	

254 carroll St. N. W. D. C.

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0-05984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15054

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		HOURS		MIN.	
Baulch		T		E		Y		1986		12		24		19		8		PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH											
F	W	21 Oct 22	64	Manassas Va.	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY													
Tak Park		Tak Park Wash Servant Home		Black - Sample Dept Store															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS													
MD		Tak Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		7102 14th St NE													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Richard		Belle Herndon																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		577-07-9669 A		Franklin Taylor		(13e)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED													
J. L. Rogers		M.D. Dep				May 6, 1986													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		May 7, 1986		Balto, Washington Laurel, P. G. Co., Md.															
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Takoma Funeral Home, Inc.		MAY 8 1986																	
254 Carroll St. N. W. D. C.																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))

H. H.

F. J. [unclear]

Richard
H.

Proctor, [unclear]
201-4-14-14 [unclear]
(10-)

Richard [unclear]

00-07934

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 15055

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
Gladys B. Taylor				May 23, 1986				5:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		2d. HOUR	
F	W	July 4, 1928	58 YRS.			May 23, 1986		1:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U S A				Montgomery, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Syl. Spg		207 Chesapeake Ave		Homemaker		Own home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Md		Montg		Syl. Spg		207 Chesapeake Ave			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Lewis W. Burke		Esta May Hottle		No		213-48-5935		John W. Taylor-Edgewater, Md. 21037	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Acute Myocardial Dis					
				(b) Chronic Myocardial Dis					
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
22b. ACTUAL SIGNATURE									
John S. Rogers, M.D.									
EXAMINER'S NAME (TYPE OR PRINT)									
John S. Rogers									
ADDRESS									
1919 Seminary Dr., S. S., Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		5/27/86		Ft. Lincoln		Brentwood, P. G., Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Takoma Funeral Home-Wash., D. C. 20012		MAY 28 1986		June Anderson-Jones					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 18. GIVE NAME, ADDRESS, AND PHONE NUMBER OF THE FUNERAL HOME TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

8

00-06471

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15056
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H Taylor			2a. DATE OF DEATH MONTH DAY YEAR 5 5 86			2b. HOUR 1934 M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Montg. Gaithersburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS - ZIP CODE 17620 Sequoia Dr. / 20877 Apt. 102			
14. FATHER'S NAME JAMES B. TAYLOR, SR.				15. MOTHER'S MAIDEN NAME Stella V. Beckwith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 111-218-20-2072		17. INFORMANT ADDRESS Grace R. Taylor (wife) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years -</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>									
19a. DATE OF OPERATION <u>2 Feb. 63</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary artery bypass</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2 Feb. 63</u> to <u>5/5 86</u> , that (I) was lost saw the deceased alive on <u>4/8 86</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.									
22b. SIGNATURE <u>John C. Fawcett M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/6/86</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Fawcett, M.D.				22e. ADDRESS 16610 Sugarland Rd., Boyds, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-10-86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. MD		
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR MAY 12 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hospital or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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0-05982

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15057

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willard John Teunis			2a. DATE OF DEATH MONTH DAY YEAR 5/5/86		2b. HOUR 5:30 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 27 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3710 Farragut Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder		12b. KIND OF BUSINESS OR INDUSTRY Consturction
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3710 Farragut Avenue. 20895	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Teunis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Bauwman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I	17. INFORMANT Edna Marie Teunis		ADDRESS Same as # 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>record</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a) <u>Pulmonary embolism, diabetes mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>1/25</u> , 19 <u>84</u> , to <u>5/5</u> , 19 <u>86</u> , that (II) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above; (II) (we) (did/did not) view the body after death.					
22b. SIGNATURE <u>B.N. ROSENBAUM, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSENBAUM		22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD. 20899			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 7, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumpfrey Funeral Homes		25a. DATE REC'D. BY REGISTRAR MAY 8 1986			
PA 300 W. Montgomery Ave. Rockville, Maryland		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

53986

REG NO. 5058

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>William D. Thomas</i>		2a. DATE KNOWN OF DEATH ESTIMATED <i>May 16 1986</i>	
3. SEX <i>M</i>	4. RACE <i>B/K</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 17 1966</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>19 YRS.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MASS.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>
10. CITY OR TOWN OF DEATH <i>B'k Spg</i>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp.</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Analyst</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>US Gov't</i>
13a. STATE <i>MD</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>B'k Spg</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Thomas</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARGARET Dalrymple</i>	16. SOCIAL SECURITY NO. <i>017-14-0914</i>	
17. INFORMANT NAME ADDRESS <i>Antonio Thomas (son) SAME AS #13</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>			
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) M.D. <i>Doc</i> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <i>George R. Snowden</i>		DATE SIGNED <i>May 16 1986</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-19-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring, Montg. MD</i>		23e. DATE RECEIVED BY REGISTRAR <i>MAY 21 1986</i>	
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE FIRST TWO PAGES, PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL OF REMAINS.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP _____
DHMH - 17
(VR A15 ME (5))
15M7/77

MAY 21 1986

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.
JAN 10 1964

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.
JAN 10 1964

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00-07146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

CLEARED BY DR. MAYLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15059
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leota E. Thompson			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1986		2b. HOUR 9:30A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 31, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilfred V. Terpening		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Finch		13e. STREET ADDRESS / ZIP CODE 8042 Inverness Ridge Road 20854			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 063-52-0369		17. INFORMANT Son		ADDRESS Donald W. Thompson same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to lungs, ribs 3 months DUE TO, OR AS A CONSEQUENCE OF (b) fracture left hip DUE TO, OR AS A CONSEQUENCE OF (c) Primary Adenocarcinoma left breast 4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Atherosclerotic Heart Disease							
19a. DATE OF OPERATION 3/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pathologic fracture left hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland 20814			
22a. I certify that (I) (the hospital) attended the deceased from October 6, 1982 to May 16, 1986 , that (I) was lost saw the deceased alive on May 8, 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated operator: I did not view the body after death.							
22b. SIGNATURE Blaine Fitzgerald				22c. DATE SIGNED 5/16/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.	
22e. ADDRESS 8218 Wisconsin Ave.				22f. ADDRESS Bethesda, Maryland 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				25a. DATE REC'D. BY REGISTRAR MAY 21 1986			
300 West Montgomery Ave. Rockville, Maryland				25b. REGISTRAR'S SIGNATURE [Signature]			

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U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

00-08662

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 15060	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEANETTE TRATEN					2a. DATE OF DEATH MONTH DAY YEAR May 28, 1986			2b. HOUR 9:15am			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dealer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Antiques			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Julius Residor					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Elfinbein		13e. STREET ADDRESS / ZIP CODE 8516 Bradmoor Dr. 20814				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Caryl Fisher		ADDRESS 2711 Weller Road; Wheaton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.0 HOURS 2 MONTHS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9 APRIL 19 86 to 28 MAY 19 86, that (I) (we) last saw the deceased alive on 28 MAY 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Walter G. Goodrich MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 28 MAY 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER G. GOODRICH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/86		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels				25a. DATE REC'D. BY REGISTRAR JUL 1 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Hartman					



00-07369

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, reinterment, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15061

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MADLINE STREVEETT			2a. DATE OF DEATH MONTH DAY YEAR 5.18.86		2b. HOUR 6:30 AM
3. SEX F	4. RACE C	5. DATE OF BIRTH MONTH DAY YEAR 6 28 02	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	12b. KIND OF BUSINESS OR INDUSTRY Investment Firm	
13a. STATE MD.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10000 Browns Blk Ave. 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Aloysius Krall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-16-1189	17. INFORMANT Nephew John C. Eisele ADDRESS 12916 Estelle Road Wheaton, Md. 20906		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Failure Immediate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Chronic Obstructive Lung Disease 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i) Renal Failure, Cardiovascular Accident					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/11 19 85 to 5/18 19 86 , that (I) (we) last saw the deceased alive on 5/11 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel J. Boyle		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel J. Boyle, M.D.		22e. ADDRESS 10313 Georgia Avenue Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE May 19, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 22 1986	

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0-06363

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 15062
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bjorn Ivar TROGSTAD			2a. DATE OF DEATH MONTH DAY YEAR May 10 th 1986		2b. HOUR 8 ²⁰ PM										
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 27, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building Supt.			12b. KIND OF BUSINESS OR INDUSTRY Constuction						
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4628 Windsor Lane. 20814						
14. FATHER'S NAME FIRST MIDDLE LAST Thorvald Trogstad			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 108-07-3128		17. INFORMANT Sonja Daly Reidsville, North Carolina 27320	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation		Minutes
DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease		Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypo Kalemia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 9, 1986, to May 10, 1986, that (I) (we) lost saw the deceased alive on May 10, 1986, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph A. Romeo MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-10-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo MD				22e. ADDRESS 10401 Old Georgetown Rd; Bethesda, Md. 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes PA NAME ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE	

CORONER NOTIFIED - BODY RELEASED

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

100-100000-1

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11/15/00 BY 60322
SP-10



00-09318

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

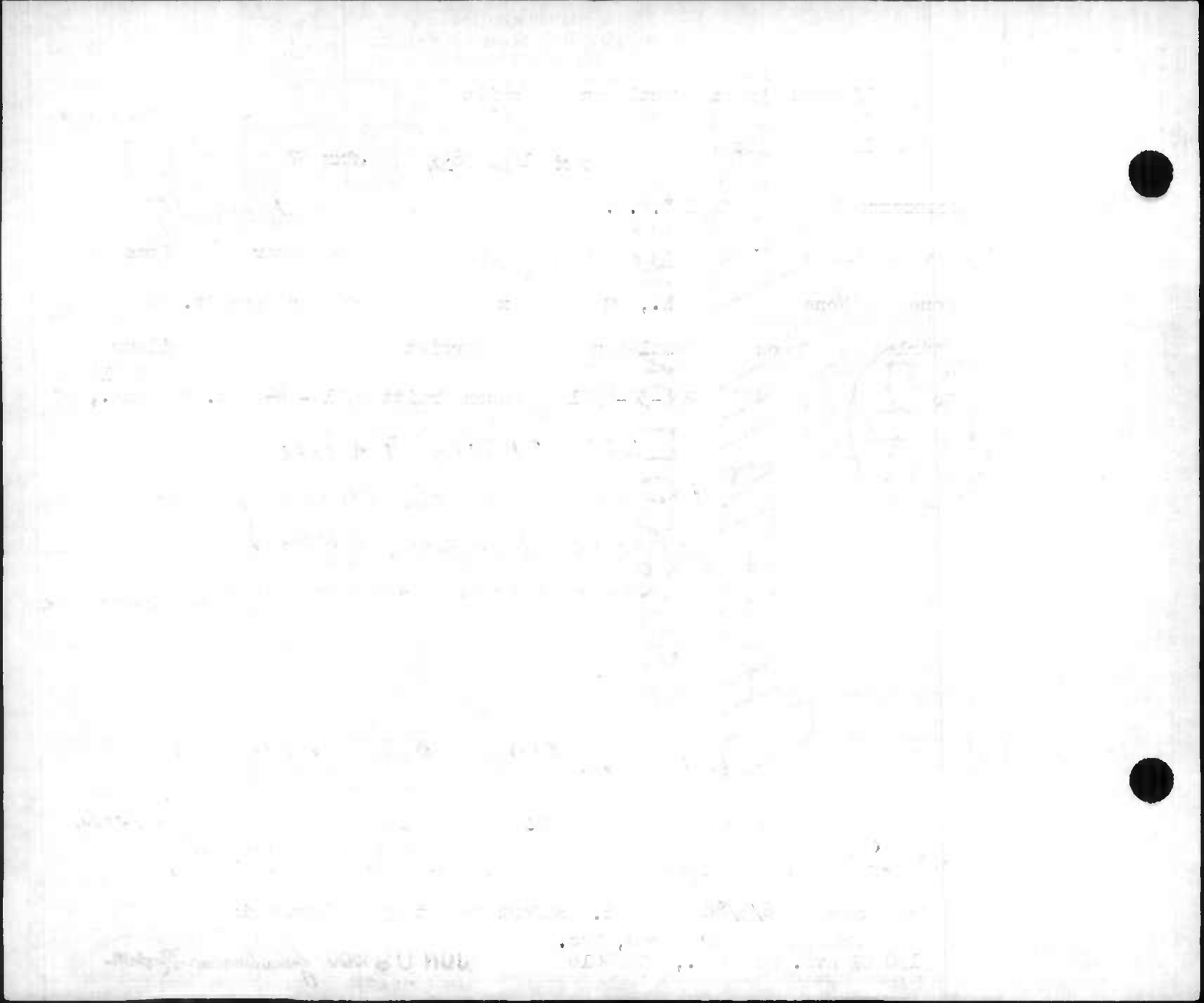
86 15063

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH MASON Castleman TRUITT				2a. DATE OF DEATH MONTH DAY YEAR 5 30 86				2b. HOUR 7:41 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 15 28		6. AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE None		13b. COUNTY None		13c. CITY OR TOWN Wash., DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3003 Van Ness St. NW 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Tyson Castleman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Wilbur					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 228-32-8371		17. INFORMANT Dawson Truitt		ADDRESS 4921 - 44th St. NW Wash., DC 20016			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia, bilateral, pleural effusion DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ALCOHOLISM; CACHEXIA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NEGATIVE FAILURE, LIVER CIRRHOSIS, ANEMIA, RENAL, OBSTRUCTIVE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 86 , to 5/30 , 19 86 , that (I) (we) lost saw the deceased alive on 5/24 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. H. H. H.				DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilhelmene Carline				22e. ADDRESS 4910 ADRIAN ST Rockville MD 20853					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/3/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria VA			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR JUN 09 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Wendell Roscoe Turner									
2a. DATE OF DEATH MONTH DAY YEAR May 20, 1986									
2b. HOUR 8:00A M									
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept 15, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14715 Essington Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Engineer		12b. KIND OF BUSINESS OR INDUSTRY H.E.W.	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 14715 Essington Road, 20853									
14. FATHER'S NAME FIRST MIDDLE LAST Sydney R. Turner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Cole					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 167 05 6279		17. INFORMANT ADDRESS Mildred K. Turner-wife- see #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Cancer - Metastatic									
DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal Bleeding									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiac Arrhythmia, History of Hypertension									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/25 19 86 , to 1986 , to Death , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. Shumaker				DEGREE				22c. DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS R. SHUMAKER MD				22e. ADDRESS 615 W. MONTGOMERY AVE ROCKVILLE, MD 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE May 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				24b. ADDRESS Federal Homes, PA				25a. DATE REC'D. BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE					
300 W. Montgomery Av., Rockville, Maryland									

MAY 22 1986

1885-0



00-05850

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15065

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIETTA K. TZACH			2a. DATE OF DEATH MONTH DAY YEAR 5/01/86		2b. HOUR 09 ⁵⁰ A.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 92	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher (Ret.)	12b. KIND OF BUSINESS OR INDUSTRY NY School Syst.	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Kaufman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bella Alexander		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 117-32-5771		17. INFORMANT Bethesda, Md. 20817 Marjorie Weiss; Daughter; 7016 Braeburn Place;	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION 2/21/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PARTIAL COLECTOMY - ADENOCARCINOMA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 10/11 19 73 to 5/1 19 86 that (1) (we) lost saw the deceased alive on 4/5 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (I) did (did not) view the body after death.					
23a. SIGNATURE EDWARD S. MEHLMAN, M.D., FCCP			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/1/86
23b. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD S. MEHLMAN			22e. ADDRESS 5625 BRADLEY BLVD., BETHESDA, MD.		
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 5/4/86	23c. NAME OF CEMETERY OR CREMATORY Cedar Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Paramus, New Jersey	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike; Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR MAY 06 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson

MEDICAL CERTIFICATION

2
9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00-000000



00-09321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8615066									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM	
Anne Margaret Ulmer						5/29/86		940 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		white		6 3 1910		75 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		USA				Montgomery county MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hosp.				Housewife		Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Mt Airy				5824 Catoclin Vista Drive 21771	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Eugene Crippen			Mary Frances Molyno						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
No		579 58 7095		Joel Ulmer		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes mellitus, Arteriosclerotic disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 5-29 1986 to 5-29 1986, that (we) last saw the deceased alive on 5-29 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
<i>John A. Rusk</i>						5-29-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
John A. Rusk, MD		58 W. BOMONSTON DRIVE ROCKVILLE, MD 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		31 May 1986		Cedar Hill Cemetery		Suitland Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert E Wilhelm Funeral Home Suitland Maryland						JUL 1 1986			

BP

00-69351



00-06277

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the accompanying pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

15067

1 DECEASED NAME (TYPE OR PRINT) Lloyd Von Blaine			2a. DATE OF DEATH MONTH DAY YEAR May 4, 1986		2b. HOUR 7:55 am
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 02 08	6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed Export-Import	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. COUNTY Montg.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4409 Prince Rd/20853	
14. FATHER'S NAME FIRST MIDDLE LAST James Blaine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Manning			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-34-7598	17. INFORMANT ADDRESS Gertrude W. Blaine same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/28 86 to 4/28 86, that (I) (we) lost saw the deceased alive on above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Ravi Passi	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/5/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVI PASSI		22e. ADDRESS 11141 Georgia Ave. Suite 104, Wheaton MD. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-7-86	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo, MD		
24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden 246 N. Washington Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR MAY 08 1986	25b. REGISTRAR'S SIGNATURE John A. Anderson		

BP



00-05915

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD WILLIAM VOSSLER			2a. DATE OF DEATH MONTH DAY YEAR MAY 1 1986		2b. HOUR A M 7:00
1. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 17 1948		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROGRAMMER		12b. KIND OF BUSINESS OR INDUSTRY COMMUNICATIONS
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OLIN RICHARD VOSSLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA MARY HARRIET WILLIAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1968-1970	17. INFORMANT ADDRESS ANNA C. VOSSLER, 3828 WENDY LANE, SILVER SPRING, MD 20906			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **LUNG CANCER**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 23 , 19 86 , to MAY 1 , 19 86 that (I) (we) lost saw the deceased alive on MAY 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>G. A. Calleja</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 MAY 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. A. CALLEJA, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 5/3/86	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.		25a. DATE REC'D. BY REGISTRAR MAY 7 1986	
1804 I ST., N.W., WASHINGTON, D.C. 20009		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DHMH - 16 60M 7/84
(VRA 15, 4)

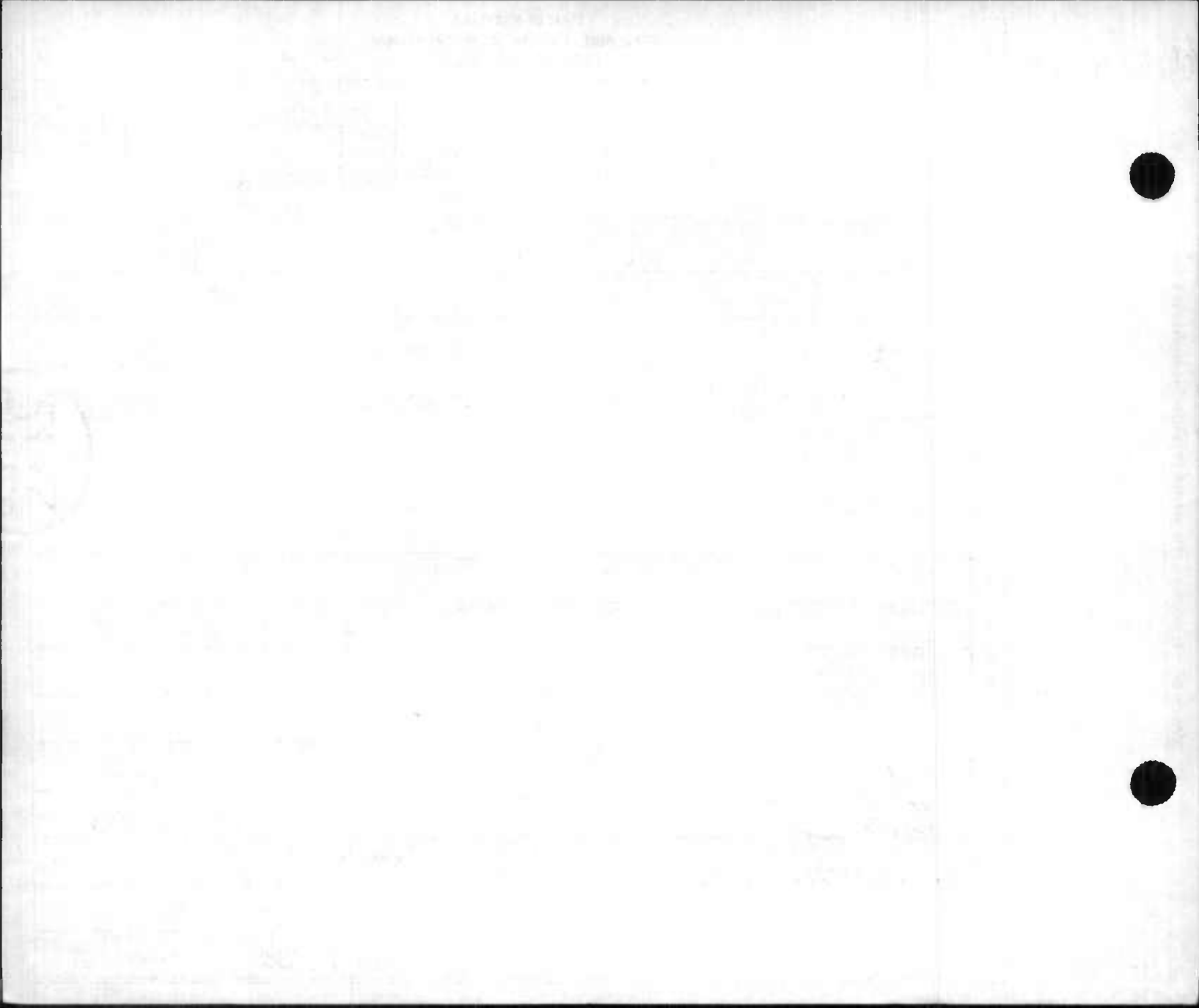
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-08073

DIVISION OF VITAL RECORDS, 201 W. BAYVIEW ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF PART 1. IN PLACE OF PART 1, WRITE "PENDING".

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BAYVIEW STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 15069

1- FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 23 1986 24 HOUR 1626 M											
1. DECEASED NAME (TYPE OR PRINT) THOMAS A WAGER										21. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 23 1986 24 HOUR 1626 M											
3 SEX M		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 1 8 20 16 YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY) 16 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		22. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 23 1986 24 HOUR 1626 M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.									
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY School									
13a. STATE MD										13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20817 6404 WHITTIER CT.					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Wager					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mayberry																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. None					17. INFORMANT ADDRESS Joseph S. Wager, same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND HEAD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) ACUTE SITUATIONAL STRESS REACTION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 2-3 HRS																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1600 P.M. 5 23 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SHOT IN ROOF OF MOUTH													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION CITY OR TOWN STREET 6404 WHITTIER CT BETHESDA MONTGOMERY MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. DEPT. MEDICAL EXAMINER				DATE SIGNED 5/23/86													
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE				ADDRESS 8500 Wisconsin Ave Bethesda MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 27, 1986				23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland									
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA																					
25a. DATE REC'D. BY REGISTRAR MAY 29 1986																					
25b. REGISTRAR'S SIGNATURE																					

07/84
25M

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DHMH - 17
(VR A15 ME (5))



00-09337

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 15070 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Samuel Waldman				2a. DATE OF DEATH MONTH DAY YEAR 05 28 86			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SURBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager (ret)		12b. KIND OF BUSINESS OR INDUSTRY Food Store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6121 Montrose Road (20852)	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Waldman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Fleisher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 113-05-1222		17. INFORMANT Elaine Koblin 6121 Montrose Rd., Rockville, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure							
19a. DATE OF OPERATION 5/19		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Failure		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5149 86 5/28 86		21g. I certify that (I) (this hospital) attended the deceased from 5/19 86 to 5/28 86 that (I) (we) lost 5/28 86 saw the deceased alive on 5/28 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
22a. SIGNATURE Raymond Bass		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bass				22e. ADDRESS 3941 Fenwick Dr. Wheaton 20908			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-86		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Upper Marlboro Maryland	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR JUN 03 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	
1170 Rockville Pike; Rockville, Md. 20852							

BP

00-000000

00-000000

00-07832

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15071

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR	
		DAFRYL		D.	WALKER		ESTI- MATED	<input type="checkbox"/>	5-25-86	19	M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR					2d. HOUR
Male	White	1 20 1961	25 YRS.	MONTHS	DAYS	5-26-86	19					1:20 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
North Dakota	U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County							MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Wheaton	4122 Sampson		Mechanic		Army							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
Maryland		Montgomery	Wheaton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4122 Sampson							20902
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Christ		Leofina		Yes		504-74-9599		Christ Walker		2034 Assumption Drive		
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST		
				Walker						Schuler		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
PART I DEATH WAS CAUSED BY:						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
IMMEDIATE CAUSE (a) Hanging												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
		2 P.M. 5-25-86		subject found hanging from an electric cord in the basement								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION								
		basement		4122 Sampson		Wheaton, Maryland						
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion				
death resulted from		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input checked="" type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED								
Dennis F. Smyth, M.D.		M.D. Assistant		5-26-86								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Lenn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION						
Burial		5-30-86		Selfridge Community Cem.		Selfridge, Sioux, North Dakota						
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
NAME		ADDRESS		MAY 28 1986								
Marzullo Funeral Service		Upperco, Maryland										

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DHMH - 17
(VR A15 ME (1))

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Mechanics

4122 Sampa...

x

Heaton

Leofina

Walker

Schuler
Blamack, North D.

Christ Walker 2034 Assumption Drive

204-74-2222

1st

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 5 0 7 2

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYDIA E. WALSH			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1986		2b. HOUR 2:45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 6, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 PENNFOREST WAY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5 PENNFOREST WAY 20853
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14. FATHER'S NAME FIRST MIDDLE LAST AUGUST BURALLI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISOLINA PELLEGRINI	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 322-10-9893	17. INFORMANT MARGARET MARY RYMAN, DAUGHTER, SAME AS ITEM #13
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov. 1984 to May 3 1986 that (I) ~~was~~ last saw the deceased alive on Mar. 6 1986, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~was~~ did not view the body after death.

22b. SIGNATURE <u>Jules R. Ladisch, M.D.</u> <u>Frederick Moormau, M.D.</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-3-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK MOOMAU, M.D.	22e. ADDRESS 18111 PRINCE PHILLIP DR., OLNEY, MD. 20832	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/7/86	23c. NAME OF CEMETERY OR CREMATORY ALL SAINTS CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE DesPLAINES ILLINOIS
24. FUNERAL DIRECTOR NAME CORCORANS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR MAY 7 1986	
6150 N. CICERO AVE., CHICAGO, ILLINOIS 60614		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of such.

Handwritten text, possibly a signature or date, oriented vertically.



Handwritten text, possibly a signature or date, oriented horizontally.

0-07348

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 7 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Edward D. Ward		May 21, 1986		3:40 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Caucasian	February 4, 1931	55	MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	United States		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital		Personnel		General Electric
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS / ZIP CODE		
13a. STATE			20855		
Maryland			17713 Park Mill Dr.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Edward D. Ward			Elizabeth Marie Linus		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife) ADDRESS	
Yes		Korea		17713 Park Mill Dr	
		168-24-2385		Yvonne D. Ward Derwood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Multiple Myeloma					years
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 80, to May 21, 86, that (I) (we) lost saw the deceased alive on May 21, 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Jules R. Lodish		M.D.		May 21, 1986	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22c. DATE SIGNED	
Jules R. Lodish, M.D.		2901 Olney Sandy Spring Rd. Olney, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 24, 1986		St Augustine Cem	
24. FUNERAL DIRECTOR		24b. LOCATION		24c. DATE REC'D. BY REGISTRAR	
Robert A. Pumphrey Funeral Home		Montgomery County Bridgeport Pennsylvania		MAY 22 1986	
P.A. 7557 Wisconsin Ave., Bethesda, MD		25b. REGISTRAR'S SIGNATURE			

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27

TO		FROM		SUBJECT	
Mr. Tolson		Mr. DeLoach		Mr. Mohr	
Mr. Bishop		Mr. Casper		Mr. Callahan	
Mr. Conrad		Mr. Felt		Mr. Gale	
Mr. Rosen		Mr. Sullivan		Mr. Tavel	
Mr. Trotter		Mr. Tele. Room		Mr. Holmes	
Miss Gandy					

100-441111-100

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW



James A. DeLoach

00-09203

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

15074

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN DAVIS WATSON			2a. DATE OF DEATH MONTH DAY YEAR MAY 29 1986		2b. HOUR P M 2:46 P		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 17 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN MCLEAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6251 OLD DOMINION DRIVE 22101	
14. FATHER'S NAME FIRST MIDDLE LAST HORACE M. DAVIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY DODSON							

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-44-8418		17. INFORMANT ADDRESS PAUL W. WATSON, 6251 OLD DOMINION DRIVE, #432, MCLEAN, VA 22101	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **MAY 4**, 19 **86**, to **MAY 29**, 19 **86**, that (I) (we) last saw the deceased alive on **MAY 29**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE <i>D. S. Reid</i>		DEGREE M.D.		RESIDENT ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 31 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. S. REID, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

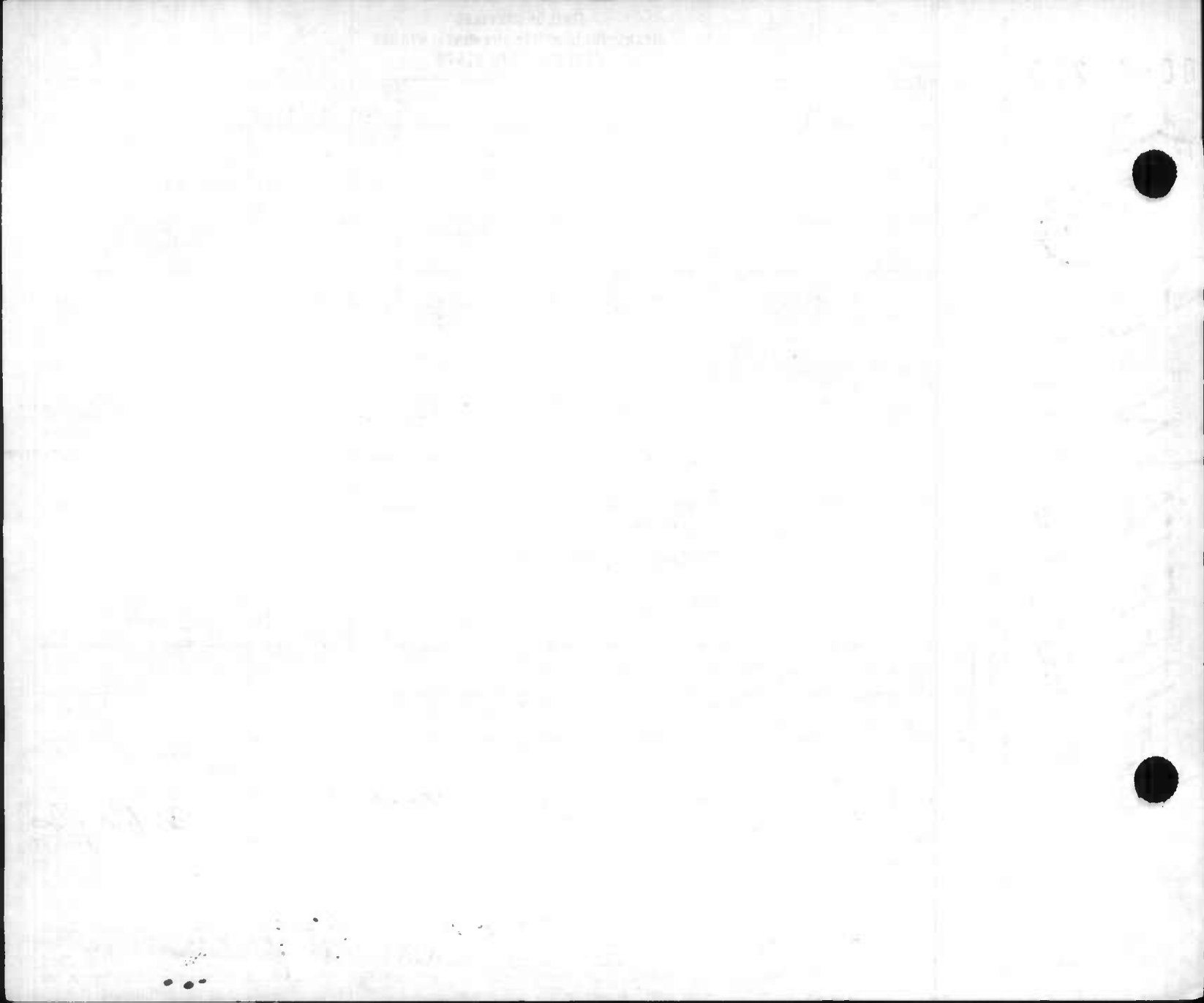
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME Murphy Funeral Home		ADDRESS 1102 W. Broad St Falls Church, Va.		25a. DATE REC'D BY REGISTRAR JUN 03 1986			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP
999999
DHMH - 16-60M 7/84
(VRA 15, 4)



00-09190

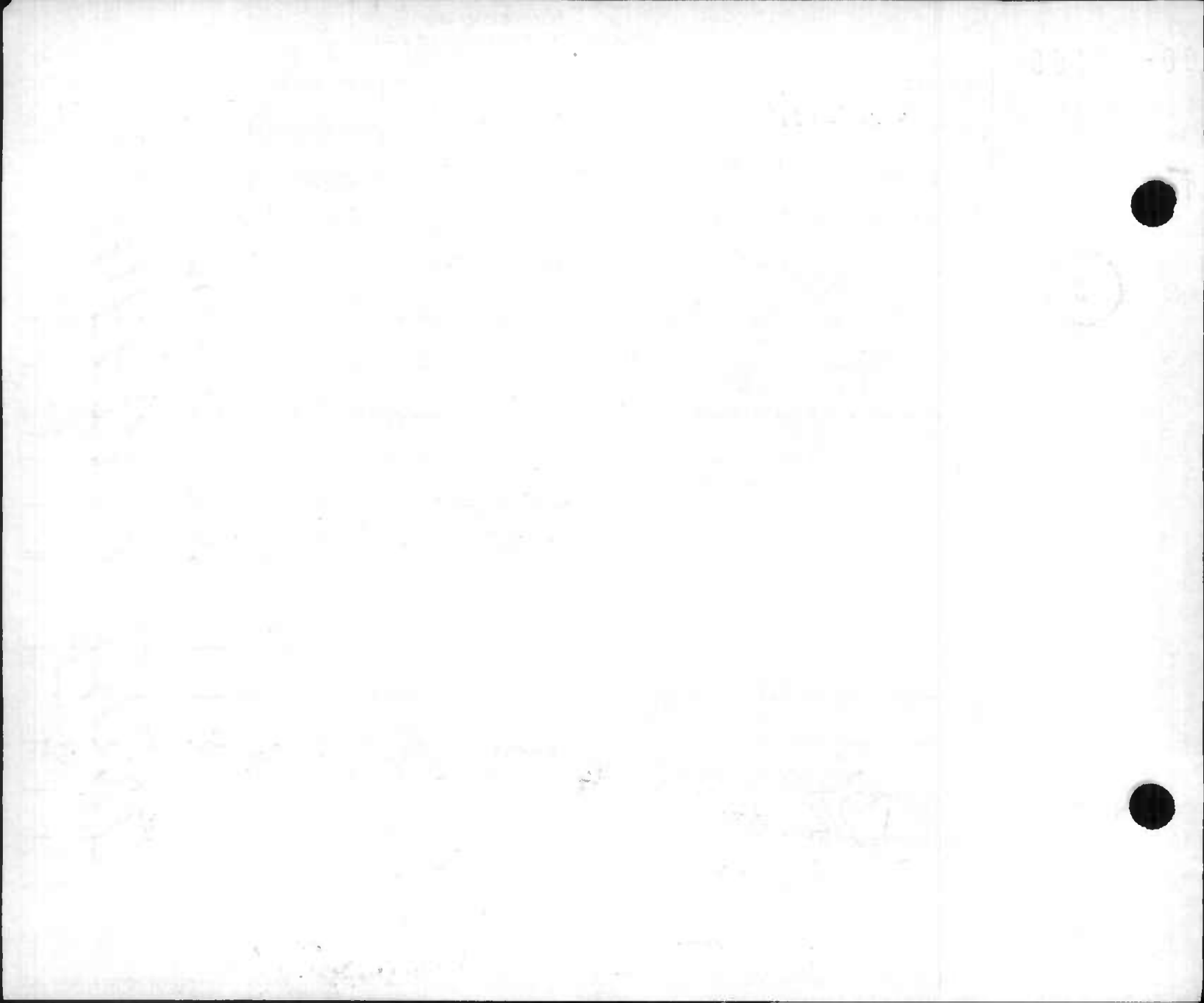
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 5 0 7 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucille KIRBY Weadon		2a. DATE OF DEATH MONTH DAY YEAR 5 30 86		2b. HOUR 0315 M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1910	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park	
14. FATHER'S NAME FIRST MIDDLE LAST Luther D. Kirby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Dyke		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-18-6384		17. INFORMANT ADDRESS Genevieve K. Bishop Waterford, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) insultion DUE TO, OR AS A CONSEQUENCE OF _____ (c) metastatic ca. of tongue					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 86 to May 30 88 , that (I) (we) lost saw the deceased alive on May 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.					
22b. SIGNATURE DJ HALDAK		DEGREE		22c. DATE SIGNED 5/30/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS Clinton Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 2 1986		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg Loudoun Va.					
24. FUNERAL DIRECTOR NAME Colonial Funeral Home		ADDRESS Leesburg, Va.		25a. DATE REC'D. BY REGISTRAR JUN 04 1986	
				25b. REGISTRAR'S SIGNATURE John Smith	



00-07826

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subpage 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

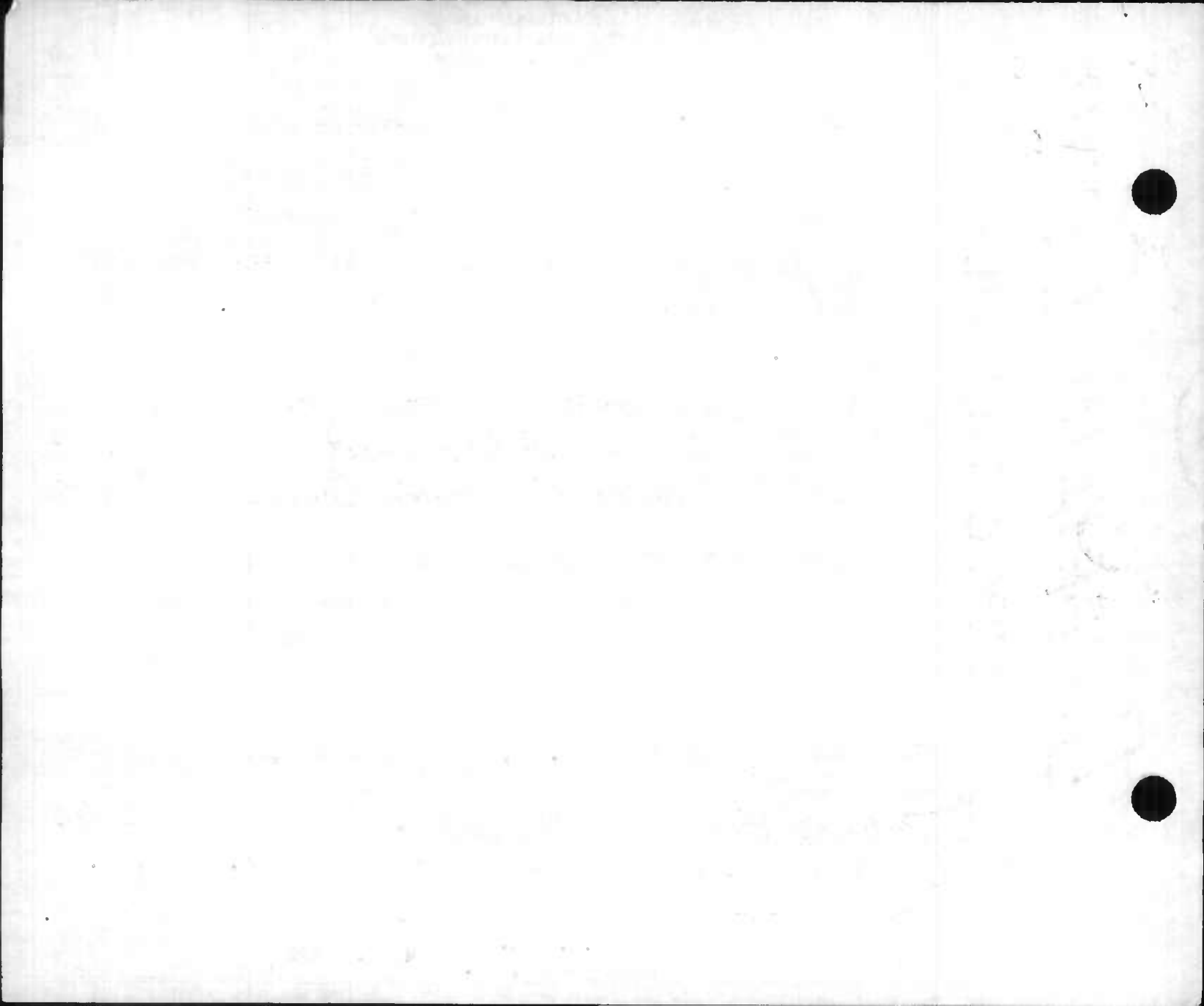
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO.

15076

1. DECEASED NAME (TYPE OR PRINT) Mildred S. Weaver			2a. DATE OF DEATH MONTH DAY YEAR May 22, 1986		2b. HOUR 7:00AM					
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9-6-1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Secty.		12b. KIND OF BUSINESS OR INDUSTRY self employed		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4709 Bready Rd. 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Sam F. Seeley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Sweet							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 213-24-3882		17. INFORMANT ADDRESS Fran Weaver-daughter-(same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ovarian Cancer DUE TO, OR AS A CONSEQUENCE OF (c) 10 months Approximate interval between onset and death: 5 minutes										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21g. I certify that (I) (the hospital) attended the deceased from Feb. 14, 1986 to May 22, 1986 , that (I) (we) last saw the deceased alive on May 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE Jules R. Lodish			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/22/86		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Jules Lodish, M.D.			22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-27-1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

BP



00-06049

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15077

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH WEICHBROD		2a. DATE OF DEATH MONTH DAY YEAR 5-4-86		2b. HOUR 4:45 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 20, 1917		6. AGE (IN YEARS (LAST BIRTHDAY)) 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Private
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Weichbrod		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sabina (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 062-07-1830		17. INFORMANT ADDRESS Ethel Weichbrod (Same as # 13)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEPTIC SHOCK		5 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a GANGRENE OF RIGHT FOOT; RENAL FAILURE; ILEUS; HEPATIC INSUFFICIENCY			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from April 30, 1986 to May 4, 1986 , that (I) (we) last saw the deceased alive on May 3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE James A. Rossi	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. ROSSI		22e. ADDRESS 6111 EXECUTIVE BLVD. ROCKVILLE MD 20852	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 5/5/1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION Alexandria, Virginia
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR MAY 07 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 indicates any injury, or other traumatic event, the medical examiner must be notified at once.)

BP



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Juliet Louise Weitzel					2a. DATE OF DEATH MONTH DAY YEAR May 20, 1986					2b. HOUR MIN 8:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3600 Tarkington Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Public Library			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 3600 Tarkington Lane 20906			
14. FATHER'S NAME FIRST MIDDLE LAST Fred William Weitzel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juliet Louise Winfield							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 679-58-5584		17. INFORMANT ADDRESS Helen W. Oxenham 3521 Tarkington Ln. S.S., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6-9- 19 81 , to 5-20- 19 86 , that (I) (we) lost saw the deceased alive on 5-20- 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jules R. Lodish, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/21/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules R. Lodish, M.D.				22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, MD 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-22-86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash. DC 20016						25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE Gabe...			

TO : Mr. Tolson, Mr. DeLoach, Mr. Mohr, Mr. Bishop, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. Felt, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

FROM : Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

CLASSIFICATION: [illegible]

CONTROL: [illegible]

COPIES: [illegible]

NOTES: [illegible]

REFERENCE: [illegible]

ACTION: [illegible]

COMMENTS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

00-07122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15019

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH MONTH DAY YEAR		2b. HOUR OF ESTI. MATED	
1- STATE REGISTRAR		ROGER CLARK WELLS, JR.		May 17 1986		10 00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	
MALE	WHITE	JAN 7, 1923	63 YRS.			May 17 1986 10 00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WASHINGTON, D.C.		U.S.A.				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS	
Bluesy		Mont. General Hosp		ENGINEER		DEFENSE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND		MONTGOMERY		SILVER SPRING		13e. STREET ADDRESS 1005 GADSDEN AVENUE 20904	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
ROGER CLARK WELLS, SR.				ETTA MAY CARD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		578-20-1607		MARY WELLS, WIFE, SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardia / bio</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
J. S. Rogers		M.D.		MAY 18, 1986			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
				CREMATION		5/18/86	
		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
		METROPOLITAN CREMATORY		ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
RICHARD RAPP, INC.		MAY 20 1986					
1804 T ST., N.W., WASHINGTON, D.C. 20009							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. WITHIN 72 HOURS, PAGES 1, 2, AND 3 SHOULD BE FILED WITH YOUR FILES. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take your copy to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or reinterment.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of it.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 6 1 5 0 8 0		7 6		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVIEVE E WELSH				2a. DATE OF DEATH MONTH DAY YEAR 05 15 86		2b. HOUR 3:27AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 23400 Welsh Rd. 20879	
14 FATHER'S NAME FIRST MIDDLE LAST William Thomas Lynch				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Allnutt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-74-2346		17 INFORMANT Sara Myers,		ADDRESS 23915 Log House Rd. Gaithersburg, Md. 20879			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial rupture DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 24 hrs. years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Diabetes mellitus, obesity									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 14, 1986 to May 15, 1986 , that (I) (we) last saw the deceased alive on May 14, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Frederick Moomau, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-15-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick Moomau, M.D.				22e. ADDRESS 18111 Prince Philip Dr., Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.			
24 FUNERAL DIRECTOR Olin L. Molesworth, P.A.,				ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE	

1931, 1932

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1931, 1932

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1931, 1932

1931, 1932

1931, 1932

1931, 1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8-6		5-0-8	
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis Andrew Wenzel				2a. DATE OF DEATH MONTH DAY YEAR 5 4 86		2b. HOUR 2030 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 19, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Oil Burner		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland P.G. Bladensburg				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Wenzel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Schatz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO 578-03-2533		17. INFORMANT ADDRESS Emily L. Wenzel (Wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma Lung, metastatic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Month 4 Month							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 86 , to 5/4/86 , 19 86 , that (I) (we) lost saw the deceased alive on 5/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Chan K. Chung, MD				DEGREE MD		22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHAN K. CHUNG, MD				22e. ADDRESS Washington Adventist Hosp, Takoma Park, Md. 20912			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/86		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL HOME NAME ADDRESS Francis G. Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

00-2701

11



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or transportation of the body. The medical examiner's office is notified of all deaths.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div>00-07124</div> <div>FOR STATE REGISTRAR</div> <div>MARGUERITE WELTI</div> <div>CERTIFICATE OF DEATH</div> <div>8-6-86</div> <div>15082</div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE W. WHITE						2a. DATE OF DEATH MONTH DAY YEAR 5 18 86			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 14, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88		7b. HOUR 4:45 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4811 OLNEY-LAYTONSVILLE ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. MAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN OLNEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4811 OLNEY-LAYTONSVILLE ROAD 20832	
14. FATHER'S NAME FIRST MIDDLE LAST H. OSWALD WELTI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELAIDE CAULFIELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-44-2080		17. INFORMANT ADDRESS JOHN W. WHITE SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOTATATIC PNEUMONIA TERM. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CONG. HEART FAILURE TERM. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTR. LONG DISEASE YRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 5/15/86 to 5/18/86 , that (he/she) last saw the deceased alive on 5/15/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (we and (aid)) view the body after death.									
22b. SIGNATURE Donald R. Lewis MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD				22e. ADDRESS OLNEY, MARYLAND 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 20, 1986		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P. GEORGE MD.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

43192-00



00-08729

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Candace Monica Williams			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1986			2b. HOUR 11:00 A.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 20 86		6. AGE (IN YEARS LAST BIRTHDAY) Newborn		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE DC		13b. COUNTY DC		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 834 Delafield Pl NW	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE Williams Jr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Ann Moseley		16. SOCIAL SECURITY NO. None					
17. INFORMANT 834 Delafield Place, NW; Washington, DC		18. CLARENCE & Doris Williams (parents) 20011							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT 834 Delafield Place, NW; Washington, DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Spontaneous Abortion - 7618 DUE TO, OR AS A CONSEQUENCE OF (c) Appendectomy 8 days before abortion PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 35 min.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suati Saraiya				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUATI M. SARAIYA				22e. ADDRESS Takoma Park, Washington Adventist Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/30/86		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.Co., Maryland			
24. FUNERAL DIRECTOR NAME LATNEY'S Funeral Home ADDRESS Washington, DC				25a. DATE REC'D. BY REGISTRAR JUN 6 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson Anderson			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and taken to the burial home permit. Then please remove all nonpertinent pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment, or interment.

IMPORTANT: If item 21 is marked emblem, infection, or other zoonotic event, the medical examiner must be notified once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

615034

KEG NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
J. CORDELIA		H.		WILLIAMS				5		19		86				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
Female		Black		Nov. 3, 1891		94		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MD		USA				MONTGOMERY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Rockville		4011 Muncaster Mill Rd.		Housewife													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MD		Montg.		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4011 Muncaster Mill Rd/								20853	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
James S. Cole		Lila V. Gantt															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		578-05-0839		Lila C. Coleburn (neice)		7809 14th Street, NW, Wash, DC										20012	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		Congestive heart failure		A.S.C.V.D.				2 hrs.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								18 yrs.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (the hospital) attended the deceased from June 19 67 to May 19 19 86, that (I) (we) lost the deceased alive on Dec. 31 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
		Frederick Moomau, M.D.						5-20-86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Frederick Moomau, MD		2901 Olney-Sandy Spring Rd., Olney, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		5-23-86		Lincoln Park Cem.		Rockville, Montg, MD											
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
George R. Snowden		246 N. Washington St. Rockville, MD 20850		MAY 26 1986		Julia Davidson-Randall											

CHARACTER OF SUBJECT'S PERSONALITY

NAME

DATE

TIME

PLACE

1. *[Handwritten: 1. ...]*

2. *[Handwritten: 2. ...]*

3. *[Handwritten: 3. ...]*

4. *[Handwritten: 4. ...]*

5. *[Handwritten: 5. ...]*

6. *[Handwritten: 6. ...]*

7. *[Handwritten: 7. ...]*

8. *[Handwritten: 8. ...]*

9. *[Handwritten: 9. ...]*

10. *[Handwritten: 10. ...]*

11. *[Handwritten: 11. ...]*

12. *[Handwritten: 12. ...]*

13. *[Handwritten: 13. ...]*



00-07032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 1B showing any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8615085

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN R. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR May 13, 1986		2b. HOUR 8 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1915		6. AGE (IN YEARS (LAST BIRTHDAY)) MONTHS DAYS HOURS MIN. 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) None		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreign Service		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Harold Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glady's Drake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT (daughter) ADDRESS Rachel McCloud, 3230 Sherry Ct., Falls Church VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 11 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5123/86 5113/86			
22. I certify that (I) (this hospital) attended the deceased from 5/12/86 19____, to 5/13/86 19____, that (I) (we) last saw the deceased alive on 5/12/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Charles P. Juvalle				DEGREE MD		22c. DATE SIGNED 5/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Juvalle				22e. ADDRESS 3301 New Mexico Ave NW DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA				25a. DATE REC'D. BY REGISTRAR MAY 20 1986			
				25b. REGISTRAR'S SIGNATURE Julia Davidson			

0-81035

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00-06442

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clyde F. Willoughby			2a. DATE OF DEATH MONTH DAY YEAR 5 2 86		2b. HOUR 10:20AM						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 7, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE			
13a. STATE VIRGINIA				13b. COUNTY ALEXANDRIA		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101-E. LURAY AVE. 22301	
14. FATHER'S NAME FIRST MIDDLE LAST COMINION -- WILLOUGHBY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RHODA -- OWENS				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) YES WW 1			
16a. SOCIAL SECURITY NO. 577-38-9154				17. INFORMANT REV. DR. RICHARD REICHARD-NLH ROCKVILLE, MD				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Resp Failure DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Obstructive Airways Disease Chronic DUE TO, OR AS A CONSEQUENCE OF (c) Acute			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 19 , 19 86 , to May 2 , 19 86 , that (I) (we) last saw the deceased alive on May 2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas E. Dooley, MD						DEGREE		22c. DATE SIGNED May 2, 1986		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, MD						22e. ADDRESS 17904 GEORGIA AVE NW OLNEY, MARYLAND 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 6/1986		23c. NAME OF CEMETERY OR CREMATORY MT. COMFORT CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA					
24. FUNERAL DIRECTOR NAME ADDRESS HYSONG CO., INC-1300 N ST., NW WASH., DC						25. DATE REC'D. BY REGISTRAR MAY 12 1986 REGISTRAR'S SIGNATURE J. Davidson-Randall					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Medical Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 1 5 0 8 7

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) AKA Judith Merice		MIDDLE R. Judith		LAST Wilner		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/ 30/ 19 86		2b. HOUR 2:40 M P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 8, 1943	6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/ 30/ 19 86		7d. HOUR 2:40 M P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5901 Devonshire Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5901 Devonshire Dr.	
14. FATHER'S NAME FIRST Jules MIDDLE LAST Rendelman		15. MOTHER'S MAIDEN NAME FIRST Hannah MIDDLE LAST Grow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-54-3232		17. INFORMANT ADDRESS John R. Wilner Same as item # 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation by Plastic Bag Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/ 30/ 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject tied plastic bag over head	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5901 Devonshire Dr., Bethesda, Montg., Md.	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 8 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CONSTANCE B. WILSON			2a. DATE OF DEATH MONTH DAY YEAR 5-9-86		2b. HOUR 1615 M.
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 14 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't Printing		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't
13a. STATE District of Columbia		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2122 Massachusetts Av., 20088
14. FATHER'S NAME (FIRST MIDDLE LAST) Walter Holland		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Maggie Burkeholder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 66 6401	17. INFORMANT ADDRESS Jack Holland, 40 Crestwood Trail, Sparta, NJ 07871			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Intractable heart failure DUE TO, OR AS A CONSEQUENCE OF Chronic Coronary artery DUE TO, OR AS A CONSEQUENCE OF 15 months					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/27 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (1st HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5/9 86	
22a. I certify that (1) this hospital attended the deceased from 5/9 86 to 5/9 86 , that (1) last saw the deceased alive on 5/9 86 , and that in (my) opinion death occurred on the date and hour and from the causes stated above; (2) I did not view the body after death.					
22b. SIGNATURE J. Blaine Fitzgerald, MD				22c. DATE SIGNED 5/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, MD				22e. ADDRESS 8218 Wisconsin Av., Bethesda, Md. 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 13, 1986	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Charlottesville, Virginia.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, ADDRESS PA 7557 Wisconsin Av., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 15 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be written by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the Medical Examiner must be notified at once.

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

100-00



00-07974

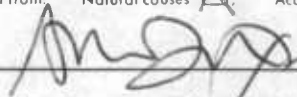
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR
7-17-86 CN

86 15089

1. DECEASED NAME (TYPE OR PRINT) DIANE E. WILSON			2a. DATE KNOWN OF DEATH ESTIMATED 5 21 19 86			2b. HOUR M		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 3, 1943	6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 5 22 19 86	2d. HOUR 11:10 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6605 Hillandale Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) District Manager		12b. KIND OF BUSINESS OR INDUSTRY Telephone
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6605 Hillandale Road 20815
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Wilson Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha A. Wilson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 152 34 7414		17. INFORMANT Bertha A. Wilson 44 Pyle St. Oradell, N.J. 07649
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER DATE SIGNED 5-23-86		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Paterson, New Jersey		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland 20814		25a. DATE REC'D BY REGISTRAR MAY 29 1986		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 10 DAYS. IF THE DEATH IS NOT FINAL, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. IF THE DEATH IS FINAL, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. IF THE DEATH IS FINAL, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. IF THE DEATH IS FINAL, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201.

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00-09176

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15090

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samuel A. Wolf			2a. DATE OF DEATH MONTH DAY YEAR 5-29-86 5:15 A.M.		
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 10, 1910	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76		7b. HOUR 5:15 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR LIQUOR STORE
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 805 LANARK WAY 20901	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY WOLF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY D. (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 577-03-7646	17. INFORMANT ADDRESS MAURICE L. WOLF, 4206 GARRETT PARK ROAD, SILVER SPRING, MARYLAND			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 10 minutes DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastrointestinal Hemorrhage / Pneumonia 1 day DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure 1 week					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus, Chronic Lymphocytic Leukemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1968 to May 29, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. P. Libre		DEGREE M.D.		22c. DATE SIGNED 29 May 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EUGENE P. LIBRE, M. D.		22e. ADDRESS 10400 CONNECTICUT AVENUE KENSINGTON, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 6/2/1986	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PRINCE GEORGE'S, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR JUN 04 1986		25b. REGISTRAR'S SIGNATURE John T. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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0-06343

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 9 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Clendenin Wolford			2a. DATE OF DEATH MONTH DAY YEAR May 7, 1986			2b. HOUR 7:20 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 5, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5681 Bent Branch Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5681 Bent Branch Rd./20816	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT ADDRESS Mary E. Sloane, Same address as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Anemia-Post AK amputation of leg									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 86 , 19 71 , to May 7 , 19 86 , that (I) (we) last saw the deceased alive on May 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles P. Duvall</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 7, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Duvall, M.D.						22e. ADDRESS 3301 NM Ave. NW Wash., DC 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/12/86		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.						25a. DATE REGD. BY REGISTRAR			
5130 Wisconsin Ave, NW, Washington, D.C. 20016						25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2110 Wisconsin Ave., N.W., Washington, D.C. 20036
 Owen Lawler's Sons, Inc.
 Arlington National Cem. Arlington, VA

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May 8, 1984

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15092

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	XX MONTH	DAY	YEAR	2b. HOUR
Andre Carlos Womack						5-23	19	86		M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Black	Feb. 22, 1957	29 YRS.			5-23	19	86		3:15 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED XX NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County, MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Hospital				Glazer/Herson Glass Company				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
District of Columbia					Washington		117 - 55th Street, S.E. (20019)			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Johnny B. Womack			Beatrice Edmonds							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No			579-74-4273			Wendy R. Pitchford Womack (wife) Wash, DC				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease		
DUE TO, OR AS A CONSEQUENCE OF		
(b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		TITLE (SPECIFY)		DATE SIGNED
Natural causes XX Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Assistant		5-24-86
ACTUAL SIGNATURE		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	23e. DATE REC'D. BY REGISTRAR	23f. REGISTRAR'S SIGNATURE
Burial	05/29/86	Lincoln Cemetery	Suitland, P.G.Co., Maryland	JUN 6 1986	Julia Davidson Henderson
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LATNEY's Funeral Home					
3831 Georgia Avenue, NW; Washington, DC 20011					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

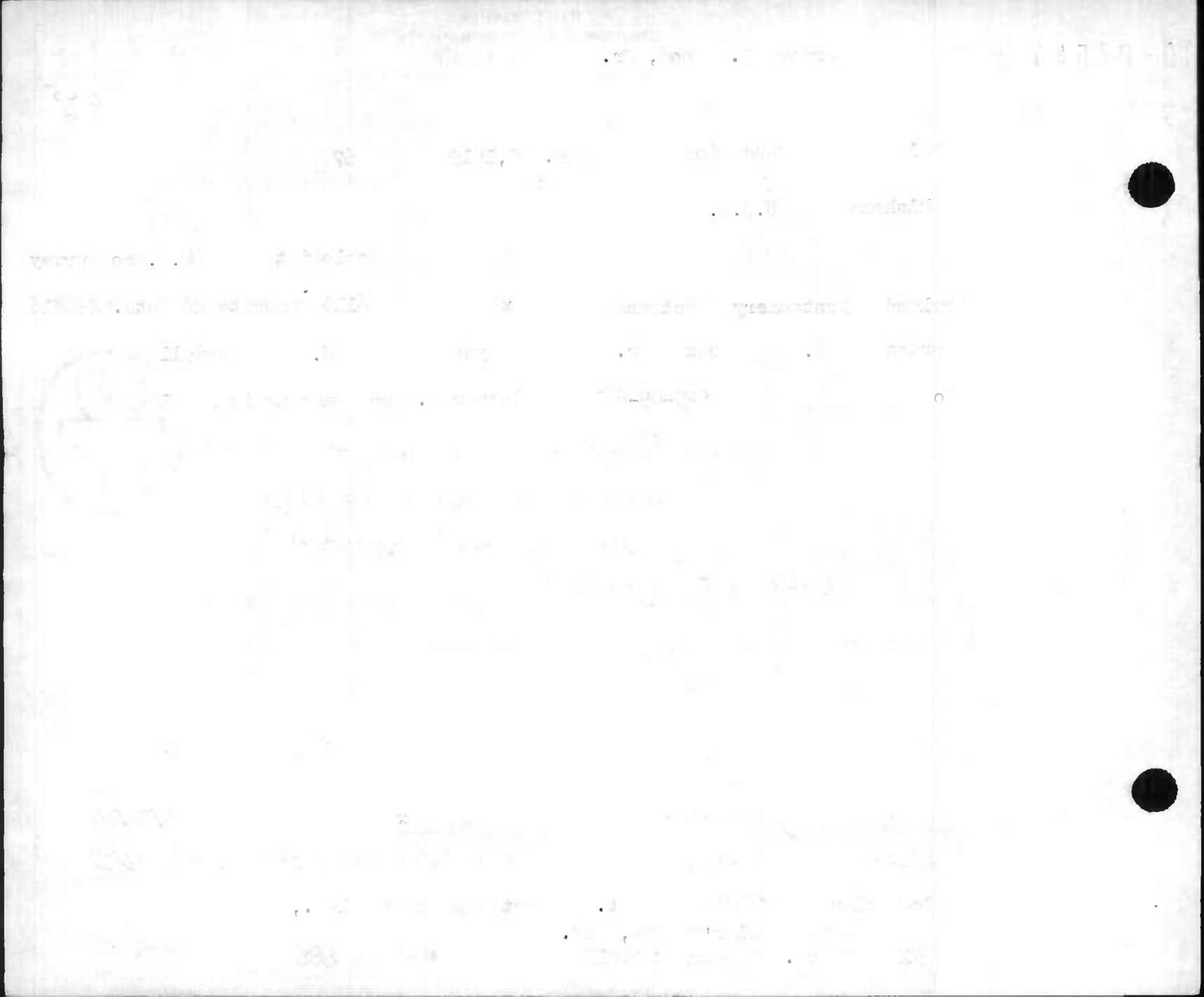
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked pr item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Gordon H. Wood, Jr. CERTIFICATE OF DEATH									
REG. NO. 8615093									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GORDON H WOOD					2a. DATE OF DEATH MONTH DAY YEAR 05 22 86		2b. HOUR 9:45 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Geologist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Geo Survey	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 6115 Ramsgate Rd Beth. Md 20816									
14. FATHER'S NAME FIRST MIDDLE LAST Gordon H. Wood Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lyde J. Lubdell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 525-09-6410		17. INFORMANT ADDRESS Eleanor S. Wood Same as item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory and Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>ischemic myocardopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary art. disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>3 occult infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5:30</u> 19 <u>86</u> to <u>5:22</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5:21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>H. Bahar</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR				22e. ADDRESS 8218 Wisconsin Ave. - Beth MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/23/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alex., VA			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 WI Ave. NW Wash/DC 20016				25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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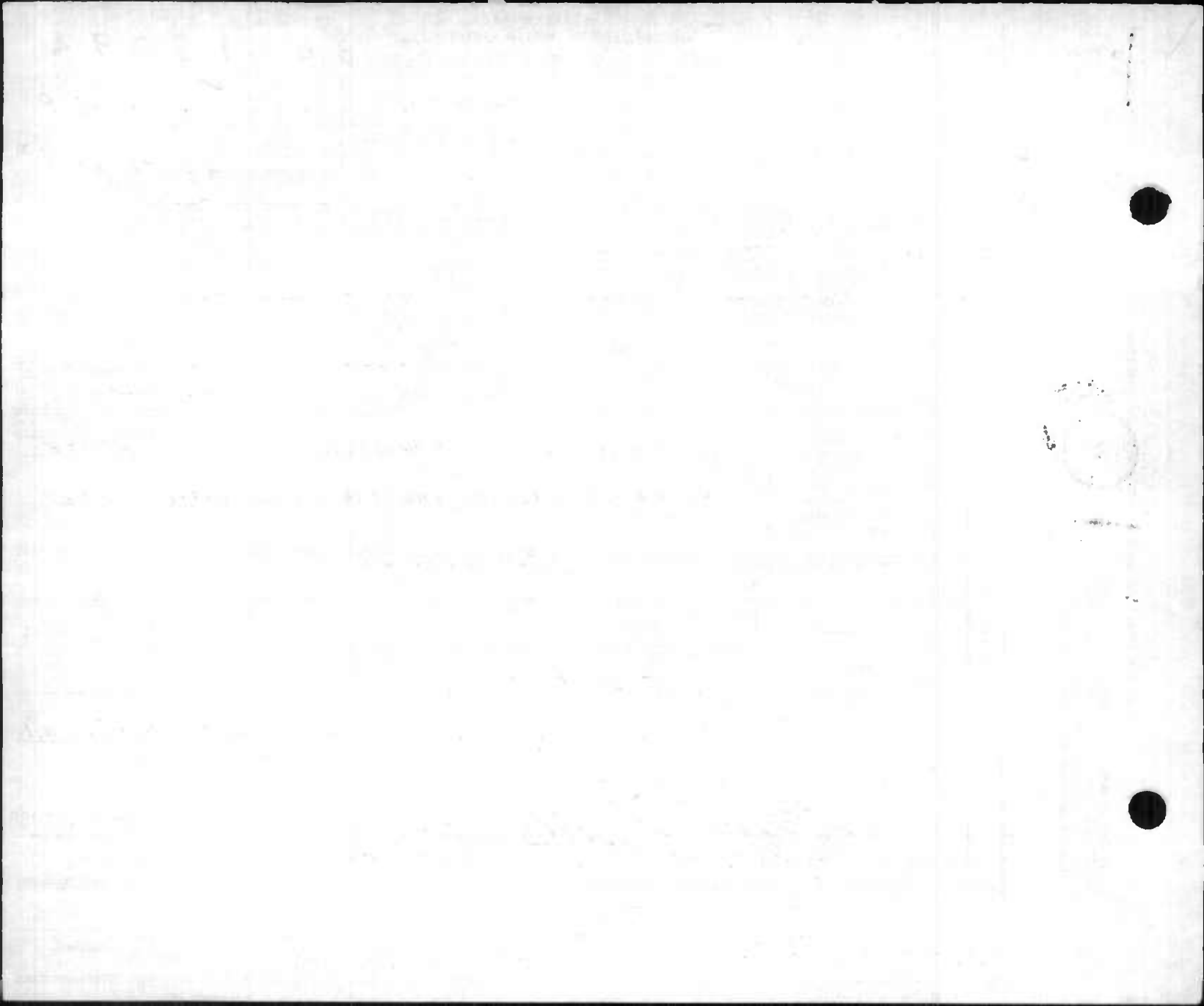
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 15094
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST		Male		Caucasian	
Hugh Rufus Wood Jr.		5. DATE OF BIRTH		6. AGE (IN YEARS)	
MONTH DAY YEAR		2 8 28		58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
Louisiana		United States		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Potomac		8212 Raymond Lane		Guidance Counselor	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Potomac	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Yes No	
Hugh Rufus Wood Sr.		Mary Alfreda Cleveland		Yes WWII	
16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS	
578-36-4492		Donna Mae Wood		8212 Raymond Lane Potomac, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) ARTERIOSECTOTIC CARDIOVASCULAR DISEASE					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
		P.M. 5 29 1986		FOUND IN CHAIR	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		Home		STREET CITY OR TOWN COUNTY STATE	
				8212 Raymond Lane Potomac MONT. MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Francis C. Mayle, M.D.		Dep.		May 30, 1986	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Francis C. Mayle, M.D.		8200 Wisconsin Avenue, Bethesda, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		June 2, 1986		Ft Lincoln Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUN 2 1986		John D. ...	
Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland					

DIVISION OF VITAL RECORDS, 30 W. PRESIDENT ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 30 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



00-06034

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

15095

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>URSULA Wood</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5 5 86</i>		2b. HOUR <i>10³⁵ AM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>CAUCASIAN</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 7 06</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>79</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN) <i>GERMANY</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNIVERSITY Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSE WIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MARYLAND</i>	13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>103 WOODRIDGE AVENUE 20901</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Luise SCHWIDDER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-38-0917</i>	17. INFORMANT ADDRESS <i>FRIEND MARYLAND 20901 HELEN GRAHAM 120 WOODRIDGE AVE. SILVER SPRING</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>End Stage Emphysema</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cigarette abuse</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Metastatic neoplasia, primary site probably PANCREATIC</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from <i>1780</i> 19 <i>5/5/86</i> 19 that (I) (we) lost saw the deceased alive on <i>4/28/86</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
---	--

22b. SIGNATURE <i>Norton</i> MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>5/5/86</i>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NORTON ELSON MD</i>	22e. ADDRESS <i>6525 Belcrest Rd Hyattsville MD 20782</i>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>	23b. DATE <i>MAY 6, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY ALEXANDRIA VIRGINIA</i>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAY 8 1986 John Davidson</i>	
500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.			

RECEIVED

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15098

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Opal V. Woodward			2a. DATE OF DEATH MONTH DAY YEAR 5-2-86		2b. HOUR 10:00 pm
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 28, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11409 Commonwealth Drive #101		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert A. Long			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Catherine Hidecker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 230-03-7017		17. INFORMANT (Husband) ADDRESS Clarence T. Woodward Rockville, MD 20852	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Lung Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1984, 19, to 5/2/86, 19, that (I) (we) last saw the deceased alive on 5/2/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jeremy V. Cooke		DEGREE MD		22c. DATE SIGNED 5/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke		22e. ADDRESS 10400 Conn. Ave. Kensington Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. NAME ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland 20814					
24a. DATE REC'D. BY REGISTRAR MAY 07 1986				24b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez	

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Cleared by Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15097
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EARL Grantly WOODWORTH			2a. DATE OF DEATH MONTH MAY DAY 1 YEAR 1986			2b. HOUR 12:38 M	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH June DAY 15 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quarter Master		12b. KIND OF BUSINESS OR INDUSTRY Federal Gov.'t	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) md				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST James MIDDLE Henry LAST Woodworth				15. MOTHER'S MAIDEN NAME FIRST Jennie MIDDLE Lorraine LAST Pack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT Mr. William A. Volkman, Personal Rep. 4308 Glenridge Street, Kensington, MD. 20895			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Acidosis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Renal Failure**

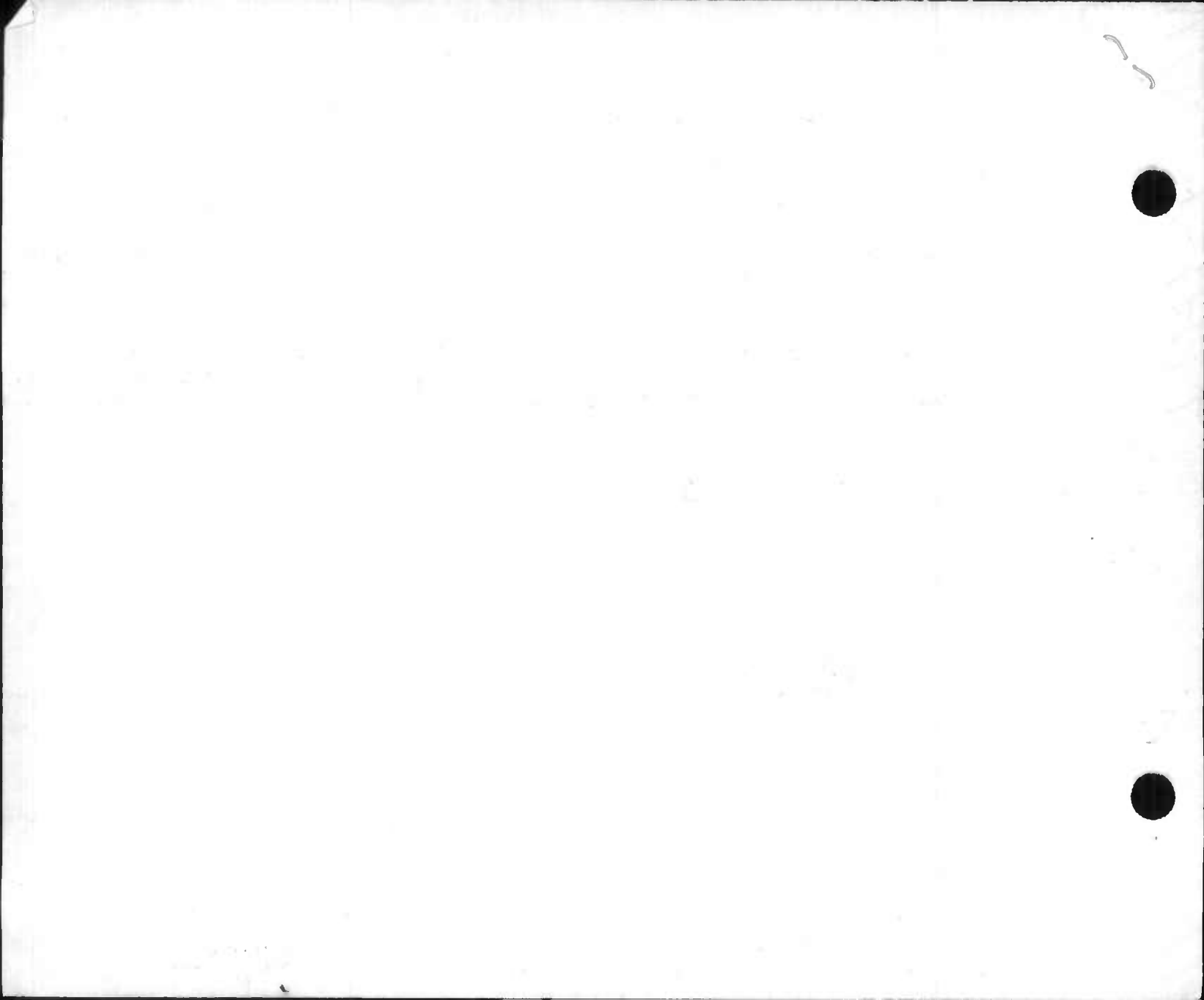
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 80 , to Present , 19 86 , that (1) (we) last saw the deceased alive on 5/1 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Hallick M.D.				DEGREE		22c. DATE SIGNED 5/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. HALLICK mp				22e. ADDRESS 11125 Rockville Pike, Rockville, Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria, Virginia COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD				25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



0-07295

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 15098

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Matilda Smith Wyche		2a. DATE OF DEATH MONTH DAY YEAR 5 10 86		2b. HOUR 8:25 AM
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9-28-1895		6. AGE (IN YEARS LAST BIRTHDAY) 90
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Takoma	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) maid	12b. KIND OF BUSINESS OR INDUSTRY private
13a. STATE MD.	13b. CITY OR TOWN Hyattsville	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 7305 Riggs Rd. #103 20783	
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown	15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE Smith LAST Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 246-46-1497		17. INFORMANT CARRIE DUNN ADDRESS 7305 Riggs Rd. #103 Hyattsville MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, Diabetes.				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased above , (I) (we) (did not) saw the body after death.				
22b. SIGNATURE Thomas J. Locke, II DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/16/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Locke, II		22e. ADDRESS 8580 Second Ave. Silver Spring, MD. 20910		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/16/86	23c. NAME OF CEMETERY OR CREMATORY Harmony Park	23d. LOCATION (CITY OR TOWN) Landover, P.P., Md.	23e. STATE MD.
24. FUNERAL DIRECTOR NAME R.N. Horton Co. Morticians Inc. ADDRESS 600 Kennedy ST. N.W. Wash. DC.		25a. DATE REC'D. BY REGISTRAR MAY 20 1986 25b. REGISTRAR'S SIGNATURE John D. ...		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon copy of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 0 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS HAGY YOUNG			2a. DATE OF DEATH MONTH DAY YEAR MAY 21 1986		2b. HOUR 6:07 A		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 2 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WARD CLERK		12b. KIND OF BUSINESS OR INDUSTRY HEALTH CARE	

13a. STATE VIRGINIA		13b. COUNTY PRINCE WM		13c. CITY OR TOWN WOODBIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FLOYD L. HAGY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SABRA COOPER		13e. STREET ADDRESS / ZIP CODE 14396 WESTMINSTER LANE #11 22193			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 408-32-4500		17. INFORMANT STEPHEN YOUNG		ADDRESS 14396 WESTMINSTER LANE, #11,	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (c)		WOODBRIDGE, VA 22193 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **MARCH 3**, 19**86**, to **MAY 21**, 19**86**, that (I) (we) last saw the deceased alive on **MAY 21**, 19**86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE B L Flax		DEGREE MD		22c. DATE SIGNED 5/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. L. FLAX, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
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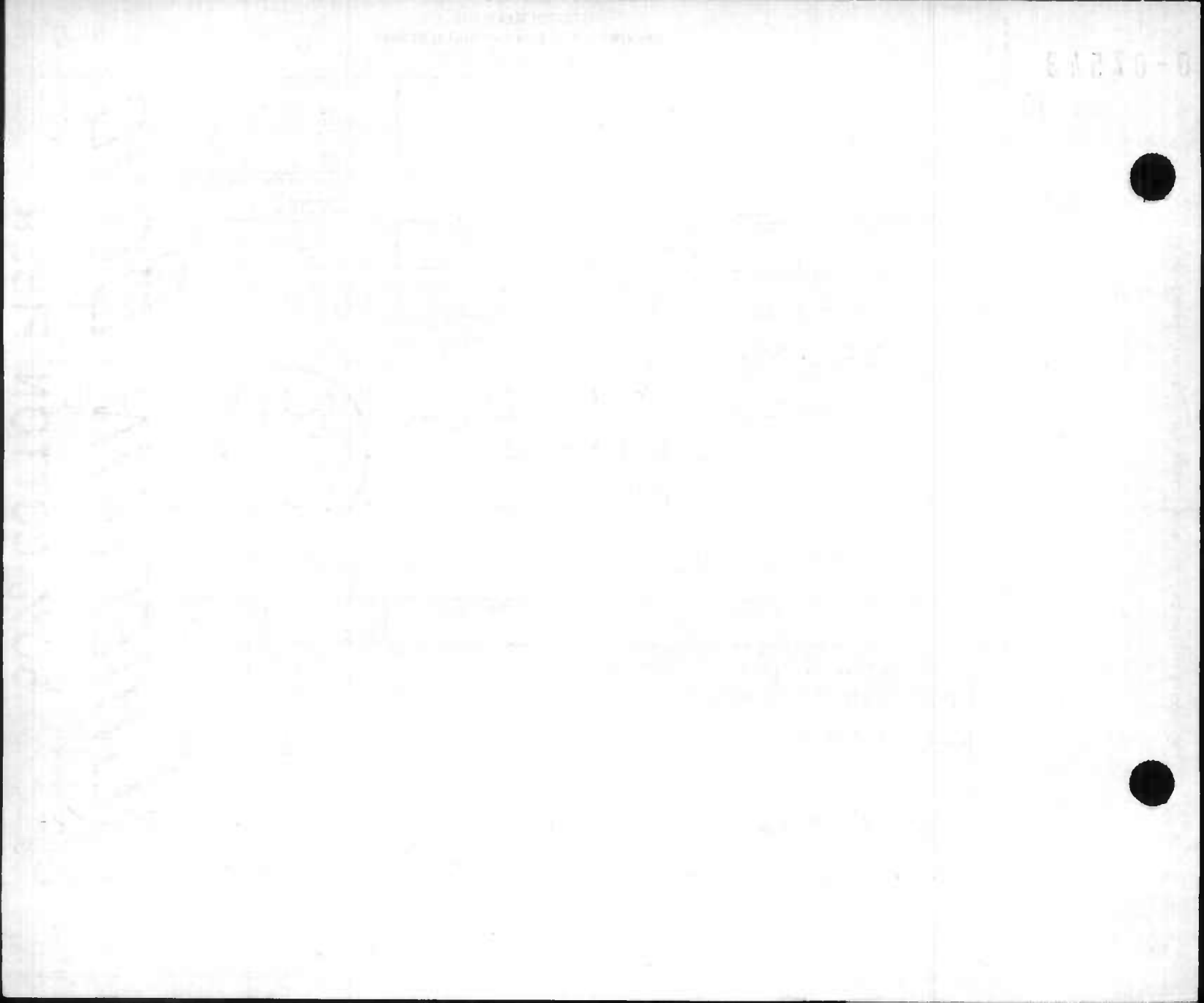
24. FUNERAL DIRECTOR NAME ADDRESS Cunningham-Mountcastle Funeral Home 13318 Occoquan Rd. Woodbridge, VA		25. DATE REC'D BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE	
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-07368

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

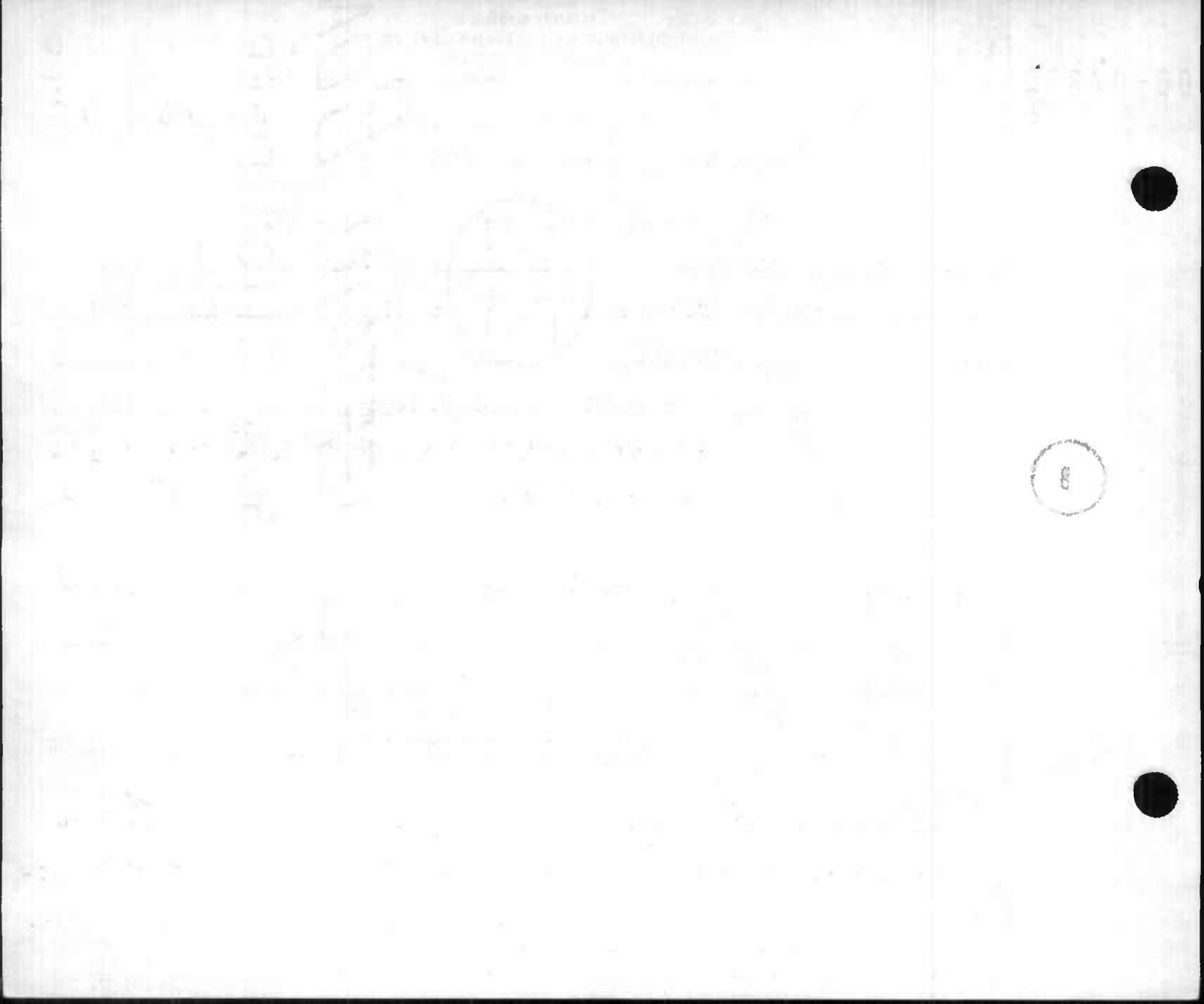
8615100

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST MIDDLE LAST			MONTH DAY YEAR			HRS. MIN.					
Elizabeth J Young			5-15-86			9 ⁴⁵ M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		Caucasian		MONTH DAY YEAR		68		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.			
New York		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring				10109 Portland Road 20901			
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
John P O'Connor			Mary Lucey			No			058-09-1177		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Latimer T. Young Husband Same As 13						(b) DUE TO, OR AS A CONSEQUENCE OF			4 yrs		
						(c) DUE TO, OR AS A CONSEQUENCE OF			13 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. PRIMARY PULMONARY HYPERTENSION b. HYPERTENSION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 18, 1977, to May 15, 1986, that (I) (we) last saw the deceased alive on May 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Francis J. Collins Jr.									5/16/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
Francis J. Collins Jr.			60400 Cornerstone Ave Kensington MD			Burial			May 19, 1986		
23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		
Gate of Heaven Cemetery Silver Spring			Montgomery Md.			Francis J. Collins Jr.			MAY 22 1986		
25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S NAME			25d. REGISTRAR'S ADDRESS			25e. REGISTRAR'S PHONE NO.		
						500 University Blvd. West Silver Spring, Md.					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO BALTIMORE CITY OR COUNTY OF DEATH: This certificate should be filed within 72 hours after death.



00-07827

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 5 1 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George N Zeppos			2a. DATE OF DEATH MONTH DAY YEAR May 23, 1986			2b. HOUR 12: noon				
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 15 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11801 Rockville Pike #1711				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Restaurant		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20852 11801 Rockville Pike #1711	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Zeppos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleni Karides							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Cleo Zeppos-wife-(same as 13e)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cerebrovascular Accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
DUE TO, OR AS A CONSEQUENCE OF (b). Alzheimer's Disease								5 years		
DUE TO, OR AS A CONSEQUENCE OF (c). Brain Tumor								2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from October 1983 to May 23, 1986, that (I) (we) lost saw the deceased alive on May 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Co. Stuart Scott MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 23, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Co. Stuart Scott MD			22e. ADDRESS 19201 Montgomery Ave. Catonsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAY 28 1986				

MEDICAL CERTIFICATION

229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

